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In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

LEROY CARHART, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

JOINT APPENDIX
(VOLUME 4)

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 4:03CV8695 (RCC)

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLINE WESTHOFF, M.D., MSC; CASSING HAMMOND, M.D., MARC HELLER, M.D., TIMOTHY R.B. JOHNSON, M.D., STEHEN CHASEN, M.D., GERSON WEISS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, ALONG WITH HIS OFFICERS, AGENTS, SERVANT, EMPLOYEES, AND SUCCESSORS IN OFFICE, DEFENDANTS

March 31, 2004

9:40 a.m.

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* * * * *

[Dr. Cassing Hammond—Direct]

[530]

MS. CHAITEN: Thank you, your Honor.

BY MS. CHAITEN:

Q. Dr. Hammond, you testified earlier that you performed procedures called D&E, is that correct?

A. That is correct.

Q. Approximately how many D&E procedures have you performed throughout your career?

A. At least a thousand.

Q. Can you just describe what is involved in a D&E?

A. Well, a D&E is really a two-day procedure, or at least a two-part procedure. The first part of a D&E involves dilating the cervix. And after the first trimester you usually can't do that adequately or safely simply by rigidly dilating the cervix with a blunt instrument as we do in the first trimester.

So, what we usually do, once you've hit about 12 weeks' gestation is we use something called osmotic dilators. There are several different types of osmotic dilators but we use them according to a protocol that we have that's gestational-age dependent and put them in the day before the—

THE COURT: Slow down a little bit Doctor, please?

THE WITNESS: I'm sorry.

We put them in typically the day before the procedure and then the next day, once the cervix has been opened by the dilators, we then proceed with the second part of the procedure [531] which is the uterine evacuation.

That part consists of reaching inside of the uterus with one of a variety of instruments and removing the pregnancy, both the fetus as well as the placenta.

BY MS. CHAITEN:

Q. Doctor, have you ever heard of an approach to D&E called intact D&E?

A. I have heard of intact D&E and have used the term. In all honesty, we use the term more with

respect to this type of legislation than we typically use it clinically.

THE COURT: Do you know what it means though? In this matter in which the term is used?

THE WITNESS: With some ambiguity, your Honor, because we try to do every D&E intact and there are variations and degrees of intactness with D&E. And I hear the term used but don't always know if every procedure that I'm doing qualifies as an intact D&E or not.

Q. Doctor, in the context of your practice, what do you consider an intact approach to D&E?

A. Well, again, every D&E that I do has as part of its goal trying to remove the pregnancy as intact and as expeditiously as possible. So, I can't really designate one specific degree of intactness that always constitutes an intact procedure.

Clearly, if I perform something such as a breech extraction procedure and have been able to accomplish a large [532] part of the procedure intact, that seems like an intact procedure to me.

Q. Doctor, you mentioned a breech extraction procedure; can you just describe briefly what is a breech extraction procedure?

A. A breech extraction refers to reaching into the uterus and if the fetus is presenting in a breech or buttocks-first presentation, grasping a lower extremity, then grasping the other lower extremity and gradually delivering the fetus—in this particular scenario, to the level of the fetal head or calvarium.

Q. Thank you, Doctor. Doctor, is it your view then that an intact D&E is a separate procedure from other kinds of D&Es?

A. No.

MS. GOWAN: Objection, leading.

THE COURT: Sustained.

Q. Doctor, have you ever heard the intact D&E approach—I'm sorry, let me restate that.

Have you ever heard the intact approach to D&E referred to by any other names?

A. Some people have characterized intact D&E as dilatation and extraction, or D&X.

Q. Doctor, you described a minute ago a breech extraction; are there approaches to D&E where the fetus is removed to a lesser, [533] less intact than the approach that you just described that you would also consider an intact approach to D&E?

MS. GOWAN: Objection. Vague, leading.

THE COURT: May I hear the question please, Ms. Reporter?

(Record read)

THE COURT: Rephrase Ms. Chaiten. It sounded leading.

Q. I will move on, that's fine.

Doctor, in the context of your practice, approximately how many times have you performed an intact approach to D&E?

A. That's really hard for me to say because, again, we are dealing with this continuum of procedures

where you're really looking at how intact constitutes an intact D&E. And, to be honest, we don't really think much about how intact we are doing it at the time. It's not something that we record or that we note or keep track of.

Now, I can tell you that in those procedures that I do between 20 and 24 weeks' gestation I am probably, in about half of all of those cases, able to extract a part of the fetal torso intact to the level of the fetal navel or above.

Q. Does that depend on fetal presentation?

A. Yes. Typically the fetus, for me to be able to do so, would have to eventually be in the breech position. It might not start out in breech position but I would have to control a [534] lower extremity to eventually proceed in that fashion.

Q. Doctor, you testified earlier that you have teaching responsibilities at Northwestern University; can you please describe those in more detail?

A. I teach medical students, residents and fellows, each appropriate to their level of training.

So, medical students at the first or second year occasionally observe us. Medical students at the third or fourth year level continue observing and occasionally will do minor forms of assistance in the operating room.

Residents are a completely different matter. People who are in residency training are training in this case to become obstetricians and gynecologists and they actually do procedures with us, though always under my supervision.

So, between the beginning of residency, which is internship and the end of residency, or even the end of

fellowship, I supervise and assist residents as they help me perform these procedures.

Q. Doctor, you mentioned the family planning fellowship program earlier, can you describe any teaching responsibilities you have in connection with that program?

A. My teaching responsibilities are predominantly to the residents and fellows when they rotate on the family planning service.

We have a fourth-year resident at any one point in [535] time who works with us on the service learning to perform first, and complicated second, trimester procedures.

We also have two fellows in the program, a first-year and a second-year fellow who are also learning to do these procedures whom I also supervise.

Q. Doctor, what types of abortion procedures are taught at your institution?

A. Well, really all of the abortion procedures that I have described. So, first trimester medical and surgical, and second trimester medical and surgical abortions as well.

Q. So, Doctor, when D&E is taught at your institution, does that include the approach to D&E that is an intact approach to D&E?

A. Well, we teach D&E. And to the extent that every D&E involves an attempt to remove the fetus as intact as possible, yes, we teach intact D&E. But I really have trouble with this notion that intact D&E constitutes the separate and distinct procedure.

It's really part and parcel of D&E in general and we teach that so we teach all degrees of intactness.

Q. Are you a member of any professional associations?

A. Yes, I am.

I am a member of the American College of Obstetricians and Gynecologists. I'm a member of the Association of Professors of Gynecology and Obstetrics. I'm a member of the * * *.

* * * * *

[543] inductions, at least through 20 weeks' gestation?

A. I think that the principal problem with induction of labor involves the so-called induction abortion interval.

The fact is, when you start an induction of labor you don't know how long it's going to take from the time that you start giving a medicine to induce labor until the abortion is complete, that is, until the patient delivers either the fetus or the placenta, or both fetus and placenta. And that's what really ends up complicating a large number of induction terminations.

We just don't know when you start this procedure that the patient will deliver within six hours, 12 hours, or in some cases we have patients who attempt induction and still haven't delivered in 24, 48 or 72 hours.

Now, to get back to your question how that implicates or how that involves safety, the longer you induce somebody the longer that they gradually accumulate the risk of certain complications, particularly infection and hemorrhage.

So, a lot of the risks of induction eventually come back to the unpredictable and often long period of time that people are waiting to deliver without doing so.

Q. Doctor, based on your experience which are more common after 20 weeks, inductions or D&Es?

A. D&Es are more common generally and particularly at our institution.

* * * * *

[548]

BY MS. CHAITEN:

Q. Doctor, let's go back to what you just testified to and break it down a little bit.

You mentioned that there was uncertainty in the length of the procedure in the case of an induction termination and you have described this to some extent, but can you explain briefly what you mean by that?

A. The uncertainty is when the patient will eventually deliver the fetus and the placenta.

We start the medicine and we don't know when that's eventually going to cause her to deliver.

Q. And you also mentioned the possibility of a failed induction; can you explain what you mean by that and how that plays into this testimony?

A. Yes.

Q. Induction of labor doesn't always work. By that you will have patients who simply don't deliver in response to this medicine and there is a point where, particularly given the patient's clinical circumstances, in other words how sick she is, that the person taking

care of her has to draw a line and figure out when enough is enough and you need to convert the procedure to a D&E.

We actually get patients referred in from the community who have sometimes been induced for a number of days who have become infected in that process and frankly come in [549] relatively sicker to us than they otherwise would have been if we had had them sooner.

[550]

Q. Doctor, you also mentioned the psychological burden on a patient who is undergoing an induction termination procedure. Can you briefly explain what you mean by that.

A. It is the burden of, first of all, not knowing when she is going to deliver, the burden of being on the labor floor and waiting and not knowing, and then also the burden of delivering the fetus.

THE COURT: When you say the labor floor, they are in a bed, aren't they?

THE WITNESS: That's correct.

THE COURT: They aren't on the floor.

THE WITNESS: I'm sorry. We commonly refer to our labor ward—

THE COURT: That is what I thought. But I sounded rather grim.

Q. Doctor, you have referred a number of times to the fact that an induction termination is performed on the labor floor. Why is that induction termination is performed on the labor floor or where labor occurs?

A. Because the patient needs to be monitored throughout that process, so they need to have appropriate nursing personnel on hand regularly checking in on them, particularly depending upon the induction agent that is the medication that is being used. We also don't know when they are going to deliver, so we wouldn't want them in another part of the hospital where we [551] might not be able to make it to the delivery as easily.

Q. Doctor, what happens if they don't deliver, if it is what you called a failed induction? Do you deal with that on the labor floor?

A. If it is a failed induction, our other alternative is to do a D&E. That could either be accomplished on our labor floor where we have the same operating rooms or we perform Cesarean sections, or we also have other operating rooms in other parts of the building, Prentiss, as well as the main hospital where we can do those.

Q. So in order to do that, the patient is taken to the operating room?

A. That is correct.

Q. Thank you. Dr. Hammond, you have now listed a number of reasons why you think that D&E is more common even after 20 weeks. Have you ever observed a patient who did not want an induction termination for the reasons that you have identified?

A. We see patients quite often who have that characteristic. We have a large number of patients who say that they do not want to have an induction after they have been counseled and are sent to our service. We also now have patients who come in to us specifically requesting that we do these procedures as

intact as possible so that they can have the benefits of both.

In other words, there are some women who want the control of the D&E and the predictability of the D&E, but they [552] would still like to be able to hold the fetus afterwards. So we now have patients coming to see if we can specifically do these as intact as possible.

Q. What do you tell those patients?

A. I tell them that we can't guarantee, that the general approach to the D&E is the same for pretty much all gestational ages and I simply don't know a priori whether or not I am going to be able to extract the fetus intact or not. But I tell them that we will do our best, as we always do, to do that.

Q. Doctor, do you ever have a patient for whom an induction termination, in your view, might not be the most appropriate medical approach?

THE COURT: At a particular point of gestation or just open-ended?

MS. CHAITEN: During the period when he can do an induction termination, which is in the second trimester.

A. Yes, I do have patients in whom medical induction is either not a wise decision or that it is contraindicated.

Q. Can you tell me what you mean by the term "contraindicated."

A. Not indicated. In other words, we see absolute and relative contraindications. An absolute contraindication would be a reason you absolutely

cannot do this procedure in the way you suggest. A relative, and that is the most applicable to D&E's, a relative contraindication would be a reason that the [553] risk/benefit ratio is tilted towards one procedure versus another.

Q. You mentioned that relative contraindications are most applicable to D&E's. Is there ever an absolute contra-indication for a labor induction?

A. There are very few, but one example would be a complete placenta previa.

Q. Before you proceed, I wanted to ask you to please explain to us what is a complete placenta previa.

A. A complete placenta previa is where the placenta or the afterbirth is completely covering the opening to the womb or the cervix. In that circumstance, the only way that the fetus can come out of the womb, out of the uterus, would be to deliver through the placenta. So not only can't you induce that to happen, but were you somehow able to do so, the patient would be bleeding very, very heavily in the process.

Q. Why is that, that the patient would be bleeding very heavily?

A. Because as the placenta separates from the wall of the uterus and is disrupted, there is a maternal hemorrhage where the placenta has been connected to the wall of the uterus.

Q. Doctor, what type of pregnancy termination procedure would you want to perform for a patient who has complete placenta previa?

A. If you think of it logically, you have only two logical [554] options and realistically only one safe option. Logically, the baby in some cases with a

placenta previa where there is a need to terminate, would need to come out either abdominally or it would need to come out vaginally through something like a D&E.

From a realistic medical standpoint, taking the baby out abdominally is not a valid option. In terms of what I mean abdominally, I am talking about something akin to a C-section, but at the gestational ages that you are talking about a C-section isn't really the same as doing what would in essence be a hysterotomy.

A uterus is a thicker, more vascular organ. You would be cutting through a segment of the uterus that not only bleeds more but is more prone to rupture in subsequent pregnancies, placing the patient's reproductive future at risk.

So almost everyone agrees that terminating a pregnancy by hysterotomy is not wise and is medically unsound except in very, very rare circumstances. So this kind of patient, a patient with a complete placenta previa who for whatever other reason needs to terminate a pregnancy, should undergo a dilation and evacuation.

Q. Dr. Hammond, can a woman with placenta previa carry her pregnancy to term?

A. Absolutely. The majority of placenta previas can be carried to term. What I was trying to indicate is if you had a [555] patient who for some reason needed to terminate the pregnancy and also had a coexistent complete placenta previa, under those circumstances D&E would be the best method of termination.

MS. GOWAN: Your Honor, I move to strike as nonresponsive to the question.

THE COURT: Could I please hear the question and answer.

(Record read)

THE COURT: Overruled.

Q. Dr. Hammond, you testified a little bit ago to the term "relative contraindications." Can you remind us again what is a relative contraindication.

A. It is a reason that kind of changes the risk/benefit ratio. By that, you wouldn't absolutely consider avoiding to do a procedure or intervention under those circumstances, but there might be something about the patient's medical history or the current clinical situation that certainly makes one a much, much better option than the other.

Q. Are there relative contraindications for second trimester induction termination?

A. Yes, there are.

Q. Could you provide some examples of those?

A. There are several. I think probably the best example is a prior uterine incision such as would be obtained from a myomectomy, which is removal of fibroids from the uterus, or [556] from a classical Cesarean section. But there are others, such as chorioamnionitis, bleeding disorders in the patient, certain kinds of heart anomalies, and so forth, that the patient has, heart disease, that I think could certainly make D&E a much better option than labor induction.

Q. Doctor, let's start with the chorioamnionitis example. Could you tell us, what is chorioamnionitis?

A. Chorioamnionitis is an infection of the amniotic fluid and the fetal membranes.

Q. Is this a serious condition?

A. It can be. It certainly justifies delivery to evacuate the uterus because the patient, the mother, is at significant risk.

Q. Why is chorioamnionitis is a relative contraindication for second trimester induction termination?

A. There are several reasons. First of all, it is not an absolute contraindication. I wouldn't fault somebody who induces labor, because the number one priority is you have to evacuate the uterus for the patient's well-being in those circumstances.

However, I think that D&E is a better choice for at least a couple of reasons. First of all, you have to contend with the unpredictable induction abortion interval that I just mentioned. A patient who is already starting infected, if she is allowed to remain infected and undelivered to one day, two days, three days, is only going to become sicker and sicker [557] during that process.

She also mounts other risk factors during that process. She is already infected, but her risk of hemorrhage is eventually greater because the infected uterus doesn't squeeze like it is supposed to after it has delivered. It is the squeezing of the uterus around the blood vessels that flow through its walls that stops it from bleeding. So a patient who is infected and has a prolonged induction is more at risk for a hemorrhage, which we already know is a greater risk with medical induction abortion than it is with D&E.

There is also another reason, which has to do procedurally. Anything that you can do that decreases

the—I'm going to end it there. I think I have adequately addressed it.

Q. Doctor, you mention that a woman could become sicker and sicker and sicker. How does that happen, aside from the increased risk of hemorrhage?

A. The patient can also become septic. By that, the infection that at first is localized to the uterus can disseminate through her bloodstream. She develops what we call sepsis, particularly gram negative sepsis, referring to the most likely bacteria involved. And that can be life threatening. It is in many cases.

Q. Doctor, how is the infection spread?

A. It is spread in a variety of ways. The bacteria enter the [558] bloodstream usually at the level of the wall of the uterus and are picked up in this manner. A lot of whether or not it is spread has to do with the inoculum, the dose of bacteria, for lack of a better way of putting it, that are eventually introduced into the bloodstream. They are also picked up as the uterus is contracting and squeezing. So the longer the induction, the greater the dose of bacteria and the greater the chance for the uterus to spread them into the patient's bloodstream.

Q. Why is that bad?

A. Because the patient can get very, very ill, and you can take what was at first a localized infection to the uterus and now generate a disseminated, life-threatening uterus to the woman.

Q. Doctor, what procedure would you think most advisable for a patient with chorioamnionitis?

A. A D&E.

Q. Can you perform a D&E safely for a patient in an emergency situation where, for example, you don't have the 24 hours to dilate the cervix that you testified to earlier?

A. Absolutely. In some circumstances, patients will have already achieved enough dilatation that you can go ahead and perform the D&E. In other cases, however, if I have some benefit that requires that I accomplish the D&E more expeditiously, I can abbreviate the preparation time somewhat. [559] To explain this perhaps a little bit further, laminaria, which are the most common dilator that we put in the cervix to open it, take about eight hours to maximally dilate. However, they achieve really good dilatation by four hours. So I know that I can often cut down on the time frame somewhat, particularly if I have a patient whose cervix is particularly predisposed to having this done.

Q. Do you ever have to terminate for chorioamnionitis on an emergency basis?

A. Yes.

Q. Does that happen frequently?

A. Yes, it does.

Q. Why is that?

A. One of the more common reasons that I am consulted at our institution is because of preterm premature rupture of membranes, which is where the amniotic sac or the bag of waters breaks sometime during the second trimester. Again, this really is what a lot of lay people might think of under more general rubric of pregnancy loss, because the prognosis for many of these pregnancies is very bad, particularly if it is earlier in gestation than the second trimester. Once

that bag of waters has broken, they have lost the barrier to infection, and a lot of germs that typically reside in the vagina can ascend and affect the fetus in the fetal membranes.

Q. You mentioned premature rupture of membranes. Is there an [560] acronym that is commonly used for that term?

A. We commonly refer to that is PPROM or PROM.

Q. So if you say PPROM or PROM during the course of pregnancy, you are talking about a situation where the amniotic sac has ruptured prematurely?

A. That is correct.

Q. Doctor, is it possible to manage the pregnancy to term if a patient is suffering from chorioamnionitis?

A. No. If a patient has chorio—and I apologize, we commonly don't said the whole word, we abbreviate it "chorio" for I think obvious reasons. The treatment of chorio is to deliver—keep in mind that there are patients who develop chorio at term. So we do have patients who will be in normal labor at full term who develop chorio, and we are simply getting those patients delivered. But at very early gestational ages you cannot manage those pregnancies expectantly once you have that diagnosis.

Q. And managing expectantly means expecting to manage the pregnancy to term?

A. Either attempt—yes, that is correct. But I would make it clear you cannot do nothing and you also cannot simply treat those patients with antibiotics. You have to evacuate the uterus under those circumstances.

Q. Dr. Hammond, you also said that bleeding disorders can be relative contraindications for second trimester induction [561] termination. Can you tell me what do you mean by "bleeding disorders."

A. There are any number of either congenital or existing from birth bleeding disorders or acquired bleeding disorders that patients can get. Some of the common examples people might have heard of would be hemophilia. There are a variety of different types. There are disorders of other clotting factors that we see. There are disorders of platelets that we run into where people lose their blood's typical ability to clot.

Q. Why would such disorders be a relative contraindication for second trimester induction terminations?

MS. GOWAN: Your Honor, I understand that Dr. Hammond is a plaintiff in this case, but he is also an expert, and counsel has qualified him as an expert to testify. Dr. Hammond's affidavit, TRO affidavit, in this case was submitted to the government as his expert report. Nowhere in that affidavit does he discuss contraindications for medical induction abortion. It is beyond the scope of the expert disclosure that Dr. Hammond has provided to the government in the case. I would like to read, if I may, your Honor—

THE COURT: No, no. Is that correct, Ms. Chaiten? Is it correct?

MS. CHAITEN: He speaks about the advisability of D&E over induction termination because for some patients it is more * * *.

* * * * *

[563]

MS. CHAITEN: Your Honor, I am simply trying to facilitate the testimony, since we have jumped ahead.

THE COURT: I will allow it just to set the stage for it. But beyond that, please don't do any leading.

MS. CHAITEN: Thank you, your Honor.

Q. Did you testify earlier that you always try to remove the fetus intact as possible?

A. Yes, I do.

Q. Is that approach to D&E that we talked about earlier what some people refer to as intact D&E?

A. Can be, yes.

Q. For ease of reference here, can we refer to the intact approach to D&E as "intact D&E"?

A. Yes, we can.

Q. Do you have an opinion regarding the safety of intact D&E?

A. I think it is a very safe procedure.

Q. Do you have an opinion as to the comparative safety of intact D&E to other second trimester abortion termination procedures?

A. I think D&E's generally are very safe procedures. But I think the more intact you can do a D&E, the safer it is for the patient. So I think intact D&E's are really the safest type, the safest variation, the safest evolution of D&E's.

Q. Why is it that you believe that intact D&E is the safest way to perform a D&E?

[564]

A. There are several reasons that I think it is safer to proceed with a D&E as intact as possible. One reason is simply that it involves fewer passes of instruments. The less that I pass an instrument into the uterus, logically, the less chance I have to perforate the uterus, which is simply to poke a hole in the uterine lining with either my instruments or one of the parts of the fetus.

THE COURT: Have you ever punctured a uterus?

THE WITNESS: Yes, I have.

Q. Doctor, can you continue to explain why you believe that—

THE COURT: Just one second. In what type of procedure did you do?

THE WITNESS: In first as well as second trimester abortions.

THE COURT: What type of abortion? What procedure?

THE WITNESS: Using both suction curettage in the first trimester and D&E in the second trimester.

THE COURT: Is that a dismemberment D&E?

THE WITNESS: Yes. I have had, like most providers, relatively few perforations.

THE COURT: I am asking about when you did have the perforation.

THE WITNESS: Yes. They have been with dismemberment D&E's.

THE COURT: Were you sued for malpractice?

[565]

THE WITNESS: No.

THE COURT: Did the patient know you perforated the uterus?

THE WITNESS: Absolutely. We always share that with the patient.

THE COURT: Go ahead. Next question.

Q. Dr. Hammond, I believe you were talking about the reasons why it is your opinion that the intact approach to D&E is the safest way to perform a D&E. I think you mentioned the decrease in the number of passes of instruments into the uterus. Would you continue with your answer, please.

A. Like I was saying, there are many other reasons that I think that it is safer to use the intact procedures. Another reason is simply that there is less of a chance to lacerate or to make a cut in the cervix. If you are doing this relatively intact, you have fewer bony parts of the fetus that are exposed that can cut into the cervix as you remove them from the patient. So the more intact the fetus, the less chance there is for those to cut the cervix and injure the patient.

Another reason is simply the degree of surgical control that we have. With very intact procedures, when I have control over the fetus external to the cervix, I can see a large portion of the procedure that I am doing. I am not having to blindly grope inside the uterus like I am with a more disarticulated or dismembered D&E, and therefore have a [566] drastically lower likelihood of perforating the uterus and injuring the cervix, because it is all exposed.

I also, particularly if this has proceeded intact to the level of the fetal head, have complete control of the head. One of the hardest parts of a D&E is if the head has been dismembered and you have to, because it is usually the last thing you have to extract, if you have to try to again grope blindly inside of the uterus, it is entirely based on your experience with the instruments and it is not something that you have the degree of surgical control over at that time. So I think surgical control is another issue.

I also think that there is less likelihood of retained products, retained material if we are doing one of these as an intact or relatively intact procedure. One of the problems with a more disarticulated D&E is you have to have some way of accounting for what you have removed from the uterus. All of us, after doing these for a while, get a gestational age-appropriate concept of what is an appropriate amount of fetal as well as placental material. But clearly, if I have watched the intact fetus delivery, I know, without having to do anything further, that I have removed the fetus intact and haven't left something behind. I also think that this is safer in the case of some fetal anomalies. I also think that the intact D&E decreases our time in the OR. I don't mean that from a matter of [567] convenience. It is simply the fact that one of the kind of standards in surgery is the less time that the patient is exposed to the procedure, the less duration of anesthetic she is receiving, the less likelihood her complications. If I can do this intact rather than having to constantly reach in and remove more and more parts, I can accomplish the D&E faster.

Q. Doctor, let's talk about your testimony that intact D&E reduces the risk of uterine perforation

because of fewer passes with instruments. Can you explain how uterine perforation would occur.

A. It can occur in one of two ways: Either because the instrument goes through the wall of the uterus or because a fetal part that has been disarticulated, particularly a sharp fetal part, is pushed by the instrument or something else inside the uterus through the wall of the uterus.

Q. What, if any, health risks are associated with uterine perforation?

A. It varies. Uterine perforations are actually more common with D&E and with first trimester abortion than many people realize. We know that from studies where they have done simultaneous first trimester abortions and tubal ligations so that they were looking into the abdomen while they were doing it.

We know that most small perforations probably cause no harm, but certain perforations cause more harm than others. If [568] it is a large perforation at the top of the uterus, the patient can bleed from it. But usually we can fix the uterus without any long-term sequelae, long-term problems.

On the other hand, a similar size perforation on the side of the uterus, which is where the blood supply for the uterus comes in, the uterine artery cones *[sic]* from the side wall of the pelvis, if you poke a hole or perforate the side of the uterus, the patient can have catastrophic hemorrhage quite rapidly, because she is bleeding from very large blood vessels.

Q. Doctor, are the risks associated with uterine perforation serious?

A. Again, there is a wide range of uterine perforations. In most cases, no, but they can be. It can vary from simply needing extra observation in the hospital to some patients requiring surgery to repair the uterus. And in other cases the only way we can control the hemorrhage is by performing a hysterectomy, which is obviously serious, because at that point the patient has lost her reproductive capacity.

Q. Why does intact D&E reduce the risk of uterine perforation?

A. Again, there are several reasons. First of all, I am just not reaching into the uterus as frequently. Secondly, when I am reaching in, I am not having to rely solely on feel. I have greater control of the fetus, often operating almost directly in front of me external to the cervix. So I am not reaching into the uterus as frequently, I don't have dismembered fetal [569] parts in the uterus that can poke through the uterus, and I have far better surgical control throughout the procedure.

Q. Doctor, you also testified that one of the advantages of an intact D&E is reducing the risk of cervical laceration or uterine perforation due to the fact that the presence of sharp bony fetal parts is reduced. First of all, can you tell us, what is cervical laceration?

A. It is a cut or a tear in the cervix, a scrape in the cervix.

Q. What causes the presence of sharp bony parts in the first place?

A. Disarticulation or dismemberment of the fetus.

THE COURT: Have you ever lacerated a cervix?

THE WITNESS: I am sure at some point that I have, your Honor. I don't specifically recall a circumstance right now.

Q. Doctor, why is the presence of sharp bony fetal parts associated with laceration and perforation?

A. In terms of perforation, obviously if you have a sharp object that is inside of the uterus and you are reaching in somewhat blindly into the uterus to grasp that sharp object, you can either directly push that object through the uterine wall or indirectly do so as whatever other parts jostle that object inside the uterus. In terms of cervical laceration, if you have exposed [570] bony fragments and you are extracting them through this ring-like structure, which is what the cervix is, they can scrape against the cervix as you remove them and lacerate the cervix.

Q. Why does intact D&E reduce this risk?

A. If you are doing the procedure intact, again, you don't expose those bony fragments, the fetus remains intact. It is more akin in many degrees of intactness to a standard delivery.

Q. Another advantage that you mentioned earlier was the reduction of retained fetal tissue or parts. What does that mean?

A. Retained parts just means that we leave something behind. It can be either the placenta or it can be part of the fetus. As I was indicating earlier, one of the things we do at the end of the procedure is to make a mental note as to whether we think that we have extracted everything that might have been inside.

In some of the cases that I have seen, that is not nearly as easy as it would seem. I have seen patients

referred in because they have fetal anomalies. So I have cases where the baby doesn't have much of its head or may be lacking extremities or any of the other landmarks that we commonly use to tell us whether we have extracted everything that we need to extract.

So if I have done this intact and have an intact fetus in front of me, then I know that I have done at least an intact [571] extraction of the fetus and have nothing else that I need to look for.

Q. Why is it important to make sure that you have removed all the fetal tissue and parts from the uterus?

A. With respect to both the fetus and the placenta, if you leave tissue inside of the uterus, the patient is at an increased risk for coming back with either an infection or a hemorrhage. Most of the time the patient will simply pass the tissue and will be fine, but many patients don't, and we eventually have to evacuate that material under less than optimal circumstances.

Q. Why does intact D&E reduce the risk of retained fetal tissue or parts?

A. As I had just indicated, because we have seen the fetus delivered. We now at that point that there is nothing that we have dismembered or disarticulated that could be remaining behind inside of the uterus. It is all at that point present and accounted for.

Q. How would you go about making sure that you have removed all of the fetal tissue and parts in a situation where you have disarticulated the fetus, or dismembered it?

A. There are several things that we do. Probably the most important is the operator's experience in assessing the feel that the uterus has afterwards. The

last part of a D&E typically involves vacuuming the uterus after we have finished * * *.

* * * * *

[573]

Q. Doctor, if you were to use an ultrasound in order to determine whether all fetal tissue and parts have been removed from the uterus, what is the patient doing while you are examining the uterus with an ultrasound?

A. At that point, the patient is still in the OR and asleep, because we use general anesthesia on our patients after approximately 16 to 18 weeks. At that point we do not want her awakened after she has already taken the risk of the general anesthetic and the intubation only to find that there are more things that we need to be removing from inside of the uterus. [B]efore we reverse the anesthetic and take her to the recovery room, we have to account for those parts. So she would still be asleep, still—I was going to say in the dorsal lithotomy position and caught myself—still basically in stirrups and basically in the position essentially of a pelvic exam while we finish this.

Q. Would reliance on ultrasound to determine whether fetal tissue and parts had all been removed lengthen the procedure?

A. It could lengthen the procedure, particularly if we were to rely on it routinely or need to rely on it routinely, especially in cases of anomalies.

Q. Doctor, you testified earlier a little bit about this and to the fact that intact D&E offers advantages because it offers the potential for shorter operating time. Can you describe why that is the case.

[574]

A. Again, I believe that the shorter operating time is not just a matter of convenience for the operating staff or the patient. It is the fact that the morbidity of any procedure, the risks in general, correlate with the duration of the operative procedure, particularly the duration under which the patient receives a general anesthetic. So anything that I can do to facilitate the procedure expeditiously and yet still retain the degree of safety that we need is in the patient's best interest. And that is actually true of most surgical procedures, not even in just obstetrics and gynecology but throughout surgery.

With regard to an intact procedure, it is usually a quicker procedure, because we aren't having to spend the time we would ordinarily take grasping within the uterus for parts of the fetus that have been disarticulated as we have been doing this procedure. Again, if we can control the lower extremity and do something like a breech extraction as I have described, I can often deliver the fetus, if not intact to the level of the calvarium, at least partially so, and obviate the need for a lot of other steps that we have to take in a more dismembered D&E.

Q. What safety advantages, if any, are associated with shorter operating time?

A. As I indicated, there is a decreased exposure to the general anesthetic, which anesthesiologists tell me is safer. [575] There is also a decreased risk of bleeding, because you simply aren't exposing the patient to the same prolonged procedure when the placenta may already have been initially disrupted and the patient starts bleeding throughout the course of the D&E. I'm

in, I'm out, the patient is no longer bleeding, her uterus is well contracted by that squeeze-down, stopping itself from bleeding, and it's over.

THE COURT: Ms. Chaiten, I am going to recess a couple of minutes early today. I have to conduct a sentence in a couple of minutes. We will break at this time and reconvene at 9:30 in the morning.

Also, Ms. Gowan, would you send us, please, one paragraph of where you think it is in the expert report that there is no mention. Ms. Chaiten can respond and direct to us a portion of that report where you this is not included.

MS. CHAITEN: Your Honor, would you like that in writing this evening?

THE COURT: It would help so we could look. We will give you a ruling in the morning.

MS. CHAITEN: I can provide you with the pages of the paragraph of the declaration and the pages of the deposition at this time, if that would be useful.

THE COURT: You can give that to my law clerk, and Ms. Gowan can do the same.

MS. CHAITEN: Thank you.

* * * * *

[Apr. 1, 2004]

[586] intact after a half hour, we start leaning in the direction of delivering it. We probably also do this simply because a lot of our induction termination patients have epidural anesthetic already on board, they are already comfortable, and it is also a good time for the patient to go ahead and effect delivery.

Q. Doctor, yesterday, when we finished at the end of the day, we were in the process of talking about the safety advantages of an intact approach to D&E, and you had mentioned that there were general safety advantages. You had also mentioned that intact D&E might offer particular safety advantages for certain patients, is that correct?

A. That's correct.

Q. What types of patients does that apply to?

A. I think there are several types of patients it would apply to. People with certain bleeding disorders, people with chorioamnionitis, people with certain types of heart disease can all benefit if I am able to do their procedures relatively intact than by dismemberment.

Q. Let's take those one at a time then. Why would an intact D&E offer particular safety advantages for women with bleeding disorders?

A. As we had talked about, a patient who has a bleeding disorder is at a greater risk of hemorrhage. During the course of a D&E, if I am able to perform the D&E relatively intact for reasons that I think I have already covered, there is less of a [587] risk of perforation, less of a risk of cervical laceration, which would be complications that would be even more devastating to a patient who has a particular bleeding problem.

So to the extent I am less likely to run into those complications in these patients, it is safer for me to do the D&E as intact as possible.

I also think it is safer because of the control we have over the timing of the procedure. Keep in mind that—I'll stop there. I really was thinking more of

induction versus D&E, which we are not talking about. I'm sorry. Go ahead.

MS. CHAITEN: Your Honor, there seems to be some feedback or something coming from the microphone as the witness is speaking. We are hearing buzzing behind us, and it is making it difficult to hear the witness.

THE COURT: Michael, could you ask the technician to come up. Do you want to take a 5-minute break here? Is it at your end, Ms. Chaiten?

MS. CHAITEN: I am hearing it behind me.

MS. GOWAN: I think the witness is too close to the microphone.

MS. CHAITEN: Am I too close to the microphone? Let's try that.

THE COURT: Back away a little bit. Try to put your hand between your mouth and the microphone. At least that is [588] something somebody has told me. See if that works.

A. Can you hear me without hearing the reverberation?

Q. Yes. I am hearing you without the reverberation.

A. I will stay back away from the microphone.

Q. Thank you. I hope I didn't interrupt you. Were you done with your answer as to why you think bleeding disorders offer a particular—

THE COURT: I think he said, I'll stop here.

Q. I didn't ask you, what do you mean when you are talking about bleeding disorders?

A. It could be one of a number of different disorders. There are problems with the factors in the blood, clotting factors that people have. Sometimes they are born with these disorders, sometimes they acquire them. Also problems with blood platelets, which are another component of the blood that is important to cause the blood to be able to clot. People can be born with these problems or develop them, even develop them as a result of certain complications of pregnancy.

Q. Doctor, you also mentioned that patients with chorio amnionitis would be offered particular advantages by undergoing an intact approach to D&E, is that correct?

A. Yes, that's correct.

Q. Just remind us briefly what chorioamnionitis is. I know we have defined it before, but there are a lot of medical terms here. Just for the benefit of the rest of us, can you briefly [589] remind us what that is.

A. It is an infection of the fetal membranes and also the amniotic fluid. We commonly, in case I lapse into this, will abbreviate it "chorio" for short.

Q. Why is it that a patient with chorioamnionitis would benefit from an intact approach to D&E?

A. There are a couple of reasons. First of all, these are patients who are already at higher risk of uterine perforation. If the uterus is infected, the wall doesn't have the usual turgor, the rigidity that it would have if it were not infected. Because of that, because of doing the procedure, as I testified, more intact decreases the likelihood of perforation, it is even more important in this kind of patient who is at higher risk.

There is another even more compelling reason, though. The more you manipulate the inside of the uterus when it is an infected environment, the more likely you are to seed the infection from the uterine lining into the blood and take a localized infection like chorio and make the patient septic, which I testified yesterday is a more disseminated infection and vastly more dangerous to the patient.

So when I am doing a D&E on somebody who has chorio, I am going to try to do the procedure with the minimum number of passes, the least intrauterine instrumentation that I can, so that I don't make the patient sicker in the process of doing [590] this.

Q. Does a patient who has chorioamnionitis have to terminate the pregnancy?

A. The pregnancy must be delivered, yes.

Q. Why is that?

A. Because it is the only way that you are really going to eventually treat the infection. You must evacuate the uterus.

Q. Doctor, the last example that you gave us of situations where a patient would benefit from an intact approach to D&E because of a particular health condition was certain cardiac anomalies or problems. Can you explain what you mean by that.

A. We see patients with lots of different heart problems. But I think what I was thinking of originally are patients who have certain severe cardiomyopathies. It could also be patients who have severe valvular heart disease. The word "cardiopathy" is essentially a problem with the heart muscle.

We see people who, because of a variety of conditions, some that they are born with and others that they acquire, the heart loses its ability to pump as effectively as it should. So with each pump of the heart, they fail to expel, to propel, an appropriate quantity of blood. What you see in these patients is much like what you see in older patients who sometimes develop congestive heart failure: Their heart has pump failure and doesn't work.

We can see similar problems in people who have [591] problems with the heart valves, the connections between the different chambers of the heart. There are a large number of these different problems, but they can either be too constricted or they can be too loose. As a result, the heart can have problems filling or it can have trouble pumping.

That is what I mean by the heart problems that I am talking about.

Q. Can you describe what the particular safety advantage would be of an intact approach to D&E.

A. I think that these are patients in whom, if you have a hemorrhage, they are at even greater risk of dying. These patients do not tolerate fluid shifts well, and what might be a minor problem in any other patient rapidly becomes a major problem in these patients.

I like the control of D&E in general in these patients because I am able to have them in the OR at a predictable time with not only anesthesiologists but the cardiologists, and so forth, and I know exactly the 20-minute period of time when we are going to be evacuating the uterus.

But in terms of doing the procedure intact, this is the last patient in the world that I want to have a uterine perforation or a bad cervical laceration on. I want the best degree of control that I can possibly get surgically. And, as I testified, I can get that degree of control with an intact procedure, at least the most intact procedure I can get at the [592] time.

Q. What are the benefits of that control of an intact procedure?

A. The benefits of the control are that I am not reaching into the uterus and having to somewhat blindly go after disarticulated or dismembered parts. I can see and feel everything that I am doing, because it is closer to me. So I am never at as heightened a risk of perforating the uterus or lacerating the cervix.

Q. Doctor, you mentioned that you would have anesthesiologists and cardiologists with you in the OR during the 20-minute or so period of the D&E. What would their role be?

A. They are actually responsible for administering the anesthetic agents but also monitoring the patient's vital signs and their response to everything I am doing. It is really a division of labor. If I am tied up doing the procedure, and this is true of most surgeries, I can't moment to moment also be monitoring the patient's blood pressure and her fluid volume status, and so forth. So both the anesthesiologist and, in the case of a patient with a major heart disease, a cardiologist can help me do those things so I can concentrate on the surgery.

THE COURT: If you did an induction with a patient that had a heart problem, would you have a cardiologist there?

THE WITNESS: We would have consulted them. But there [593] is no way of knowing if they would be there immediately at the time of the delivery, because we never quite know when the patient is going to deliver.

THE COURT: Once you knew there was going to be a delivery, would you call upon a cardiologist?

THE WITNESS: We would certainly be calling them and trying to get their advice by phone.

THE COURT: Or attendance, I assume, if you thought it was necessary, right?

THE WITNESS: We would certainly try. But it is far less predictable with an induction, because we don't know when the patient is going to actually deliver.

THE COURT: Once you know that is happening, can't you call? Isn't there a cardiologist on duty?

THE WITNESS: Yes, and we would call that person.

THE COURT: OK.

Q. Doctor, in situations of certain bleeding disorders, are there medications that can be given a patient during the time of the procedure that might assist you in alleviating the concerns you have resulting from this health condition?

A. Yes, there are. It is actually advantageous when you are doing a D&E, because depending on the bleeding disorder, we can often give the patient those medicines immediately before the procedure, when she is most at risk.

For example, if a patient has extremely low platelets, [594] less than 10,000 particularly, we could commonly give the patient platelets immediately before the procedure, when she is most at risk of bleeding. Platelets, for whatever reason, that are donated to a patient don't have the normal life span of platelets that your body makes. So there is a window after you have given them when the patient will benefit from that infusion of platelets. With a controlled D&E, I can give them immediately beforehand and know that it is going to be effective at the time I am operating.

Also, one of the more common clotting factor problems, you had asked about these, is something called von Willebran's disease. It is a problem with, I won't belabor this, but the factor 8 complex, which is also involved in hemophilia. It is much more common, it is much more common in women. We do see this. And there is a drug called DDAVP, which they can actually give nasally immediately beforehand when we know exactly when the patient is going to deliver.

Q. Doctor, the maternal health conditions you have just described, are any of these conditions that might arise after a pregnancy has commenced?

A. Yes.

Q. Which ones?

A. Thrombocytopenia, for example, which is low platelets, I'm sorry, and is a blood clotting problem, can actually arise as a result of the pregnancy. People who develop the Help syndrome [595] of a variety of variants of preeclampsia and toxemia will often exhibit low platelets and they will lose their blood's ability to clot. That is one example that can arise over the pregnancy.

Chorioamnionitis, by definition, arises after the pregnancy because it is an infection of pregnant material.

Q. Thank you, Doctor. I would like you now to turn to the black binder that is in front of you. Do you have it there from yesterday?

A. Yes, I do.

Q. If you would turn to what has been marked Plaintiffs' Exhibit 69, and it should be at tab 69 in your binder.

A. Yes.

Q. What is that?

A. This is the Partial-Birth Abortion Act of 2003.

Q. Have you reviewed this Act in its entirety?

A. Yes, I have.

Q. If you would, please, refer to section 2 of the Act, entitled "Findings." Do you see that on the first page?

A. Yes, I do.

Q. Then, if you would look under the findings to section 14(A), which is on page S3-4, do you have that in front of you?

A. Yes, I do.

Q. Doctor, would you please read that paragraph for us.

A. "Partial-birth abortion poses serious risks to the health [596] of a woman undergoing the procedure. Those risks include, among other things, an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation, making it difficult or impossible for a woman to successfully carry a

subsequent pregnancy to term, an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech presentation, a procedure which, according to a leading obstetrics textbook, 'there are very few, if any, indications for other than for delivery of a second twin,' and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death."

Q. Thank you, Doctor. Do you see there in the first sentence the reference to partial-birth abortion?

A. Yes, I do.

Q. I would like for purposes of the next number of questions for you to assume that the procedure that we are talking about here is the intact approach to D&E. Assuming that what we are referring to is the intact approach to D&E, based on your experience, do you agree with the statement that an intact D&E "increases the woman's risk of suffering from cervical [597] incompetence as a result of cervical dilation"?

A. No, not at all.

Q. Why not?

A. I don't think that there is really any data that substantiates that cervical incompetence is more common in these patients. In fact, there is some data that if you appropriately dilate the cervix in these patients, they are not at a heightened risk of having a subsequent obstetric bad outcome, let alone cervical incompetence.

Q. Doctor, do you do anything different when dilating for an intact D&E than when you dilate for any other D&E?

A. Again, as I testified, I consider all D&E's part and parcel of the same procedure. The truth is we do nothing differently before our intact procedures, our relatively intact procedures, than for those that are done by dismemberment.

Q. You mean you do nothing different in dilating for those, is that what you said?

A. That is correct. We have a protocol that is dependent upon the patient's gestational age, and we do the same thing for all of those patients.

Q. Doctor, I would now like you to look at the sentence in that paragraph that you read—not the sentence, but the phrase that refers to an increased risk of uterine rupture, and it goes on from there. Do you see where I am talking about?

A. Yes, I do.

[598]

Q. Again assuming that we are talking about an intact D&E, based on your experience, what, if any, opinion do you have about the statement that there is an increased risk of uterine rupture from an intact D&E?

A. I think that it is completely untrue. In fact, I think there is less of a risk of uterine rupture to the extent there is less of a risk of uterine perforation.

Q. Based on your experience, and again assuming that we are talking about intact D&E, what, if any,

opinion do you have about the statement that there is an increased risk of abruption from intact D&E?

A. Abruption is separation of the placenta, and it is something that we do surgically during these cases. So there is really no difference in risk of abruption with these procedures.

Q. Again based on your experience and assuming that we are talking about an intact D&E, what, if any, opinion do you have about the statement that there is an increased risk of amniotic fluid embolus from an intact D&E?

A. I know of absolutely no data regarding that. Frankly, I doubt it has ever been looked at, simply because the overall incidence of amniotic fluid embolism is extremely low. Before any D&E, regardless of how intact it is, the first step that we take is to evacuate the amniotic fluid.

The only exception is some of our PPROM patients like [599] we talked about yesterday, where there is no amniotic fluid to begin with, where we occasionally omit that step. But we do that to decrease the risk of amniotic fluid embolism, and we do it in every procedure regardless of the degree of intactness that we anticipate.

Q. Doctor, do you believe that there is an increased trauma to the uterus from an intact D&E?

A. No. I think the risk of trauma is much less if we are able to do the procedure more intact.

Q. Why is that?

A. As I testified, we are taking fewer passes into the uterus. The less I put an instrument into the uterus, the less likely it is that I am going to perforate

the uterus. If I also have not dismembered the fetus as much, I do not have exposed bony spicules that I can push through the uterus, causing a perforation, or that I can pull out, subsequently lacerating the cervix. So the more intact, the less likely I am to traumatize the uterus.

Q. Doctor, for any of these complications that we have just talked about—uterine rupture, abruption, amniotic fluid embolus, or trauma to the uterus—are you aware of any peer-reviewed studies that have ever determined that any of these complications increase in intact D&E?

A. No, I am not.

Q. Doctor, I would like you now to look at that same phrase a [600] little farther down, where it says that "there is an increased risk of trauma to the uterus as a result of converting the child to a footling breech position." Do you see that?

A. Yes, I do.

Q. It goes on from there to talk about "a procedure which, according to a leading obstetrics textbook, there are only a few, if any . . ."—I'm sorry—"a few, if any, indications for . . . other than delivery of a second twin." Again assuming that we are talking about intact D&E, based on your experience, what, if any, opinion do you have about the statement that intact D&E causes trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, there are few, if any, indications for other than delivery of a second twin?

A. I think the statement is completely untrue. First of all, the procedure that they are talking about in

the obstetric textbook is doubtlessly internal podalic version. So really what they are talking about are apples and oranges.

An internal podalic version is a procedure usually accomplished near term or at term, which we only now do to deliver an after-coming twin. It involves reaching in, taking a term or near-term baby that is coming out head first, grabbing the foot, converting it to a breech, and attempting to deliver it. This is a risky procedure at term with these [601] babies, because you can traumatize the full-term uterus and injure the mother, and you can also traumatize the baby in the process of doing it.

But we are not really concerned with that at 20 weeks' gestation, when the uterus is a very different organ. What we are doing is manipulating a much smaller, less traumatic fetus, in the sense that it is not nearly as likely to injure the pregnant woman, inside a very, very different uterus. So, first of all, they are talking about very different procedures. In terms of the safety of manipulating that fetus, this is something that is common to every D&E, whether it is an intact D&E or not. At 20 weeks' gestation, the likelihood that a baby is breech, which is buttocks first or head down, or vertex, or sideways, which is transverse, are all roughly equal. It is not like at term.

So very common in any D&E, even if it is by dismemberment, we will reach in, we will convert a fetus that is initially transverse to breech or convert one that is head first to breech. We don't always know that we have done this, but it is a common part of every D&E.

D&E has been studied for 30 years and been shown to be a safe procedure. Clearly, this manipulation isn't causing any harm to the patient, whether we do it intact, relatively intact, or by dismemberment.

Q. Doctor, do you have an understanding of what obstetrics [602] textbook the Act is referring to when it says "according to a leading obstetrics textbook, there are very few, if any, indications for this procedure other than delivery of a second twin"?

A. I am not exactly certain. My assumption is Williams Obstetrics, because it is one of the more commonly used textbooks. I think that if you look in either Gabbe's text or Williams', you are going to find something decrying the use of internal podalic version. But, again, that is not what we are doing at midtrimester. That is a completely different procedure that I think is being used completely out of context in this case.

MS. GOWAN: I move to strike the answer of the witness: Lack of personal knowledge.

THE COURT: Could I hear the question.

(Record read)

THE COURT: What is your objection?

MS. GOWAN: He said he didn't know, your Honor. He said "I assume."

THE COURT: Doctor, first of all, you throw in two texts. Do you know whether it is from one of those two texts for sure?

THE WITNESS: I don't know which exact text they were using, no, your Honor.

THE COURT: But you are more than willing to speculate [603] that it is taken out of context and it is not appropriate, even though you don't know?

THE WITNESS: Yes, sir.

THE COURT: I will sustain the motion.

Q. Doctor, are you aware of whether in Williams Obstetrics—

THE COURT: Do you have the text there, Ms. Chaiten?

MS. CHAITEN: I do not have Williams here. I think Ms. Gowan may have it.

MS. GOWAN: I do not.

MS. CHAITEN: We have it as an exhibit.

THE COURT: It seems like it isn't worth all this questioning speculation. If you want to show him the text, show it to him. Why should we all wonder?

MS. CHAITEN: Your Honor, I'm not sure I need to do that.

THE COURT: If he doesn't know, he doesn't know. Why don't you move on. It seems to me we are all spinning our wheels about a text you are not showing him. And you don't know that that is what is referred to in the statute. Until you establish that, it seems like a pointless exercise.

MS. CHAITEN: Thank you, your Honor.

Q. Doctor, are you aware of any obstetrics or gynecology textbook that decries the use of conversion to a breech position in a second trimester D&E procedure?

A. No.

[604]

Q. Doctor, turning back again to this paragraph that you read for us, assuming that we are talking about an intact D&E, based on your experience, what, if any, opinion do you have regarding the statement that intact D&E poses a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal?

A. Again, I don't believe that statement is true.

Q. Why is that?

A. If anything, I think that this procedure exposes the patient to less of a likelihood of perforation or laceration.

Q. Why?

A. There seems to be a misunderstanding of what we are doing when we decompress the calvarium, or the skull. Whenever I do this to decompress the calvarium, keep in mind my patients after 16 to 18 weeks are all under general anesthesia.

THE COURT: Excuse me. Is a calvarium the skull?

THE WITNESS: I'm sorry, your Honor. Yes, it is the skull or the head. I will try to say that from now on instead of "calvarium."

THE COURT: I don't mean to put words in your mouth. I just want to make sure I know what you are saying.

A. So when we do this procedure, I've got the patient asleep, I've got a device that I can hold on to the top of the cervix with. If I have done a procedure that

is intact enough that we [605] have delivered the fetus intact to the level of the head, where only the head remains above the level of the internal opening of the cervix, I can actually see at this point the back of the neck of the fetus.

I can lift the cervix, look at the back of the neck, and then with a scissors, which we have on our operating table, make an incision in the back of the fetal neck. That whole time I can see what I am doing. And in the very rare cases where I can't see what I am doing, I can usually put my finger, in fact always put my finger, on top of my scissors, which are against the back of the fetal neck, and I have complete control and feeling the entire time I do this.

In those cases, feeling is just as good as seeing. I know exactly where the scissors are. They are not anywhere near the patient's cervix or uterus. It is a completely visible, completely palpable in the sense of feeling operation.

If you contrast that with a D&E that is by dismemberment, the last part of the procedure usually involves trying to get the head, or calvarium, out. What I am having to do in one of those procedures is to try to feel with an instrument up inside the uterus with this skull that is bobbing at the end of my instrument, and I have to get around it. I don't have control of that part. So I think doing the decompression procedure exposes the patient to less risk, not more, because it is a much more controlled, straightforward [606] procedure.

THE COURT: Have you ever lacerated a uterus doing this?

THE WITNESS: No, never.

THE COURT: Or the —

THE WITNESS: I'm sorry?

THE COURT: Go ahead. Next question.

Q. Doctor Hammond, have you ever lacerated the uterus in the process of using a scissors to make an incision in the back of the fetal neck in the course of conducting the intact approach to D&E?

A. I just want to be clear about the question. I think it is a question of perforating the uterus and lacerating the cervix.

Q. Have you done either of those in the course of using a scissors ot */sic/* make an incision in the back of the fetal neck?

A. Never, no.

Q. Dr. Hammond, do you always use scissors or other instruments to breech the fetal head or the fetal neck in the course of doing an intact D&E of this kind?

A. Not always. It depends on the fetus. If you've got a fetus that is earlier in gestation, the skull, or calvarium, is softer. It isn't as firmly formed. So in those cases you can often to this just with your finger, you can do this digitally. In some cases with scissors, probably after 20 weeks I am more likely to use them. We actually have a number of instruments [607] on the table that I can use, whatever seems like it is going to be most effective.

Q. Doctor, does it increase any risk to the patient to make an incision in the back of the fetal neck in the course of doing this sort of an intact D&E?

A. No, it does not.

Q. If you would now look at to section 2(2) of the findings, which should be back on the first page of the

statute, where it says, "Rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but in fact poses serious risks to the long-term health of women and in some circumstances their lives."

Do you see what I am referring to, Doctor?

A. Yes, I do.

Q. Again assuming that we are talking about the intact approach to D&E, based on your experience, what, if any, opinion do you have about the statement that intact D&E in fact poses serious risks to the long-term health of women and in some circumstances their lives?

A. That is untrue.

Q. Why do you believe that?

A. I think that doing these procedures as intact as possible [608] is safer for patients and protects their health and their lives.

Q. Why is that?

A. As I have testified, I think there is a much lower risk of perforating the uterus, of lacerating the cervix. I think there is less likelihood of significant blood loss with the procedure. I have greater surgical control. It is just all-in-all safer to do these procedures as intact as possible.

Q. So for all of the reasons that you have been testifying over the last day or two, right?

A. That is correct.

Q. Doctor, can you now turn to paragraph 13 of the findings section. I'm sorry to be jumping around like this. It is on page S3-3.

A. I think I'm there.

Q. It says, "There exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a health exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care." Doctor, again assuming that we are talking about the intact approach to D&E, do you agree with the statement that intact D&E is never necessary to preserve the health of a [609] woman?

A. No, I don't agree with that statement.

Q. Why not?

A. Because, again, as I have testified, I think that doing D&E's as intact as possible is the safest method of performing a D&E. So once the patient confronts the need to terminate a pregnancy, this will be the safest method for the patient.

Q. Do you agree with the statement that the intact approach to D&E poses serious risks to a woman's health?

MS. GOWAN: Objection: Asked and answered.

THE COURT: Sustained.

Q. Do you agree with the statement that the intact approach to D&E lies outside the standard of medical care?

A. Not at all.

Q. Why is that?

A. Because I think it is the standard of medical care. I think that since I have been doing this, a goal of D&E has been to accomplish that the procedure is intact as possible. What we are seeing with the procedures we are describing is simply an evolution of these procedures. It has been the standard of care for at least the 15 years that I have been doing this.

Q. Doctor, would you now look to section 14(B) of the finding on page S3-4.

A. Yes, I see this.

Q. Would you read the last sentence for us, please; beginning [610] "Indeed."

A. "Indeed, unlike other, more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions and their curriculum."

Q. Assuming that we are talking about the intact approach to D&E, do you agree that, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include instruction on intact D&E in their curricula?

A. That is clearly untrue. We have done it at Northwestern since I have been there. We have students who are involved in these procedures and know what we are doing, so are our residents and so are our fellows.

Q. Are you aware of any medical texts or other teaching materials that discuss intact D&E?

A. The one I am most familiar with is called a Clinician's Guide to Medical and Surgical Abortion. It has a number of different editors, but it is a book that we refer many of our residents and fellows to when they come on the family planning service and want an abortion resource.

Some newer editions, obstetrical texts, also refer to —the current edition of Williams Obstetrics, in fact, has a reference to intact D&X.

THE COURT: When you say a "reference," do they * * *.

* * * * *

[612]

Q. Dr. Hammond, I have handed you a copy of what has been marked Plaintiffs' Exhibit 70. You have it in front of you. Can you please identify this.

A. Yes. This is a photocopy of A Clinician's Guide to Medical and Surgical Abortion.

Q. Is this a copy of the text you referred to a few minutes ago when you were answering my last question?

A. That is correct.

Q. Thank you.

THE COURT: Are you one of the editors?

THE WITNESS: No, I am not.

Q. Doctor, will you look at paragraph 14(F) of the findings. This appears on page S3-5, where it says, "A ban on the partial-birth abortion will therefore advance the health interests of pregnant women seeking to terminate pregnancy."

A. Yes, I see it.

Q. Do you see it? OK. Assuming we are talking about intact D&E, do you agree that a ban on intact D&E's will therefore advance the health interests of pregnant women seeking to terminate pregnancy?

A. No, I don't.

Q. Why not?

A. Because I believe that a ban on this procedure will place patients at risk by removing from their possible options a procedure that is often the safest choice that they would have.

[613]

Q. Doctor, will you now look at paragraph 14(J) of the findings, where it says, "Partial-birth abortion also confuses the medical, ethical, and legal duty of physicians to promote life as the physician acts directly against the physical life of a child whom he or she had just delivered all but the head out of the womb in order to end that life."

Based on your experience and again assuming that we are talking about intact D&E, do you agree with that statement?

A. No, I do not.

Q. Why not?

A. Because the patient that I am taking care of in these procedures is the woman. I am actually acting on her behalf using the procedure that is safest under these circumstances to preserve her health and protect her life.

Q. Doctor, do you have an understanding—

THE COURT: Excuse me. You don't feel any obligation whatsoever to protect the life of the fetus?

THE WITNESS: We are seeing—

THE COURT: I am asking you something. Yes or no.

THE WITNESS: With many of my patients, yes, particularly post-viability, your Honor.

THE COURT: You don't find any dual responsibility? Your obligation is only to the woman?

THE WITNESS: In the circumstances in which I am doing terminations, that is correct.

* * * * *

[626] overt act other than completion of delivery that kills the partially delivered living fetus."

Q. Doctor, you testified that this language is so broad as to potentially encompass many of the second trimester abortion procedures you perform, is that correct?

A. Yes, it is.

MS. GOWAN: Objection: Leading.

THE COURT: I will allow it.

Q. Let's go back through the language and break it down so that you can explain why you have concerns. Beginning with the first line, "deliberately and intentionally vaginally delivers," does that cause you concern?

A. Yes, because every single procedure that I perform in any abortion, whether it is a medical induction abortion or whether it is a D&E, is deliberate

and intentional and results in vaginal delivery. It doesn't distinguish anything for me.

Q. The ban refers to "living fetus." Does that term have meaning for you?

A. It has meaning, but it can be more vague than might be apparent. We sometimes are concerned about the issue of viability. So there is living in the sense that there is a heartbeat or sign of life. But the more important issue with respect to when I perform an abortion, since we don't do these post-24 weeks, post-viability, is the likelihood that the fetus can have sustained survival outside of the womb. That can be a [627] little bit confusing. Do they mean simply sign of life or do they mean a viable fetus? There is no reference in this ban to viability.

Q. Do you understand "living fetus" to mean sign of life?

A. That is my interpretation of this, yes.

Q. In the earlier gestational age?

A. Yes.

Q. Doctor, do you understand the term "head-first presentation"?

A. Yes, I do.

Q. What is that?

A. It means that the fetus is presenting with the head nearest the person who is—nearest the opening, nearest the cervix.

Q. You have described already for us during your testimony what a breech presentation is, is that correct?

A. That is correct. It is where the buttocks is presenting nearest the cervix.

Q. Looking at the language outside the body of the mother, do you understand what that means?

A. No. It is confusing.

Q. Why is that?

A. It sounds like it wouldn't be confusing, but I think if you are in an operating room, or a delivery room for that matter, and see what the anatomy is like in reality, it is far less clear what constitutes outside of the body of the mother. One * * *.

* * * * *

[630]

A. I think this could sweep in many of the second trimester surgical procedures I do. Frankly, I think they could even be interpreted in ways that could sweep in some medical abortions that we do, some medical induction of labor abortions.

Q. So you believe it would apply—when you refer to surgical procedures, are you talking about D&E?

A. Yes.

Q. And medical inductions?

A. That is correct.

THE COURT: Do you think that sweeps in dismemberment D&E?

THE WITNESS: I think it potentially could, your Honor.

Q. Doctor, why don't you explain for us how you think that could happen.

A. How it could sweep in which?

Q. Dismemberment D&E, in response to the judge's question.

A. It might be easiest if I just take you through some of the language of the ban and describe what could happen easily during one of my D&E's. There are several ways, your Honor, that this could happen, so bear with me. First of all, every D&E that I do involves deliberate and intentional vaginal delivery. I am always deliberately dilating the cervix and I am eventually going to vaginally deliver the fetus. [631] Let's skip for purposes of my current example the head-first presentation and move on to "in the case of a breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will," and so forth.

Let's say that I have a patient I have achieved adequate dilatation and I reach inside the uterus, have not controlled the lower extremity, but I grasp part of the fetal abdomen first. That can happen, and it has happened to me before with certain anomalies. So the very first thing that I take out of the vagina is the top of the abdomen or part of the fetal thorax. In that case, I have started a dismemberment D&E and I have delivered outside of the body of the woman a part of the fetal trunk past the navel.

I then proceed to do the rest of my D&E by dismemberment. I know that that dismemberment itself is going to result in demise of the fetus, and therefore I think every act I take in the remainder of that dismemberment D&E could be interpreted to be an overt act that I know the fetus isn't going to survive.

In that kind of a scenario, I think that I could potentially trip this ban.

Q. Doctor, you mentioned that there were a number of examples of how that might happen. Can you give us just another one, how the ban's language could apply to a dismemberment D&E.

A. It might be easiest if I took you through an example in [632] which we start with a fetus breech. Let's say that the fetus is presenting breech and the first that I do is I grasp a lower extremity. I pull on the lower extremity until the fetus—until I'm able to extract as much as possible before meeting resistance. I often meet resistance at the level of the fetal umbilicus, or the belly button, the navel.

What I often do at that point is I do something to decompress, because you have now got the umbilical cord at the cervix, you are often pushing intraabdominal contents above the level of the cervix, and I need to do something unless the cervix is going to—excuse me, I misspoke—because the fetus is going to tear. Because I try to do this as intact as possible, what I will often do at that point is make an incision beneath the belly button, an incision in the fetal abdomen, to permit decompression of the fetus. It increases the likelihood that I might be able to do this intact.

Depending onto degree of intactness, whether I have delivered a part of the fetal trunk above the level of the navel beyond the cervix at this point, ignoring the ambiguity in what constitutes out of the body of the mother, I know that the fetus can't survive that act of making an incision in the abdomen, and I think that I

will have tripped the language of the ban in that circumstance also.

Furthermore, if preceding this I had dismembered part [633] of the lower extremities of the fetus, let's say that to get to this point where I can pull the fetus out so that something is exposed beyond the level of the navel, let's say that I disarticulate the fetus completely at the pelvis, I think that I could be performing a disarticulated or dismemberment D&E and could till */sic/* trip the language of the ban, because I have delivered the fetus such that I have exposed part of the fetus above the level of the navel and then performed the act, this case dismemberment, that could be the overt act that the fetus isn't going to survive.

Q. Doctor, in that example, let's take that last example, have you deliberately and intentionally vaginally delivered a fetus?

A. I'm sorry?

Q. Have you intentionally and deliberately vaginally delivered the fetus?

A. Yes.

Q. Have you intentionally and deliberately delivered it as far as possible, including past the umbilical cord, past the navel?

A. In that example, yes, I have.

Q. Have you intentionally and deliberately taken steps that you know will kill the fetus?

A. In that case, yes, I have.

THE COURT: But you have delivered it in parts, haven't you?

THE WITNESS: Yes, I have.

[634]

THE COURT: There lies the distinction, doesn't it, Doctor, from the language that you are so afraid of?

THE WITNESS: Yes, sir, that is one of the things I am afraid of.

THE COURT: But it is a difference: You have delivered it in parts?

THE WITNESS: In that case, yes. That is why I am worried about this. I was giving an example of why a dismemberment D&E could trip the ban. I would still have swept in the language of the ban while performing, in essence, a dismemberment D&E.

Q. Doctor, in any of the examples that you have just given us, have you taken the steps that you have taken for the purpose of delivering the fetus to a point past the umbilicus, or the navel, in order to perform an overt act that you know will kill the fetus?

A. No. The purpose in performing the procedure is to evacuate the uterus, to do the pregnancy termination. It is not for the express purpose of performing any of these specific acts or performing an act that will result in fetal demise.

Q. Doctor, does the word "intact" appear anywhere in the language of section 1531(B)(1) that we have been talking about?

A. No, it does not.

Q. Doctor, you testified earlier to a situation you described as PPROM, or preterm premature rupture of membranes. Can you [635] remind us again what that is.

A. That is where the bag of waters, or the amniotic sac, ruptures before the onset of labor, and in the case of true PPROM, at a very premature time in pregnancy. With reference to our current discussion, we see this happening in the second trimester.

Q. How do you typically treat a patient who presents with PPROM?

A. Logically, you have two choices: Either you do nothing and see if that patient can gradually progress until the fetus is viable in the sense of having a reasonable likelihood of sustained survival, and for the patient then to eventually spontaneously deliver, or you terminate the pregnancy. Some patients, if they have ruptured the amniotic sac, will eventually develop chorioamnionitis—"chorio," again, for short —which, as we talked about, is an infection inside the uterus. Then they would have to be delivered.

Q. What procedure would you counsel such a patient to undergo in order to terminate a pregnancy?

A. If she is before 24 weeks, I would counsel the patient to undergo a D&E.

Q. Do you have an opinion as to whether the definition of partial-birth abortion contained in the Act could cover treatment of such a patient?

A. Yes. I think it can.

[636]

Q. Why is that?

A. In many of these cases in which I am consulted, the fetus is still alive. So really the only thing different procedurally from anything that I have talked about today is the indication. These patients for most intents

and purposes are experiencing a type of pregnancy loss, particularly with the earlier ruptures in the second trimester.

THE COURT: Does that mean a miscarriage, Doctor?

THE WITNESS: Yes, your Honor, it can.

A. The prognosis for the pregnancy in those cases where the bag of waters ruptures very early in pregnancy, particularly if there is virtually no fluid remaining around the baby, is very, very grave, so many of these patients decide to terminate. From that point forward, it is the same as D&E in most cases.

Q. Did you ever do dilation of a woman who has PPROM?

A. It varies. Some of these patients have already achieved some degree of cervical dilatation. Obviously, if they are already dilated enough, I occasionally don't have to do the step involving osmotic dilators. In most cases we still have to do this, and there is no problem doing so in a patient once the bag of waters has broken.

Q. In treating a woman with PPROM, do you have to deliberately and intentionally reach in with your instruments in order to vaginally deliver the fetus?

A. Yes, I do.

[637]

Q. Do you have to take all of the other deliberate and intentional steps that you testified that you do in any D&E?

A. Yes, I do.

THE COURT: Ms. Chaiten, is this a convenient time to take our morning break?

MS. CHAITEN: That would be fine, your Honor. Maybe I can organize my notes a little and wrap up.

THE COURT: Great. We will take our morning recess.

(Recess)

* * * * *

[639] another look at it.

You testified earlier that the word "intact" does not appear in the Act's definition of partial-birth abortion, is that correct?

A. That is correct.

Q. Is that a concern for you?

A. Yes, it is.

Q. And why is that?

A. Well, as I think I mentioned earlier, I believe that many of even the dismemberment D & Es that I performed eventually fall within the scope of the ban.

Q. The statute says, partially vaginally deliver a living fetus; does that help you to understand better whether dismemberment procedures would be covered by the ban?

A. Well no, it doesn't, becaue it's possible, as I was testifying, to have started this delivery, have dismembered part of the fetus, and yet the fetus could still have a sign of life such as a heartbeat, and I could then deliver the remaining part of the fetus above the level of the navel and I believe sweep into, and I believe in those circumstances could potentially have violated the ban.

Q. In that situatoin, would you have partially delivered a living fetus—I'm sorry—partially vaginally delivered a living fetus?

A. Yes, I would.

[640]

Q. And would you have delivered it to a level past the umbilicus, or the navel?

A. Yes.

Q. And, in doing so, would you then take steps that you know would kill the fetus?

A. Many of the steps that we take during the abortion know that the fetus will not survive.

Q. And would—

THE COURT: The moment you dismember it it is going to bleed to death, isn't it?

THE WITNESS: But we don't know exactly when demise is going to occur, your Honor.

THE COURT: But start it.

THE WITNESS: Yes.

BY MS. CHAITEN:

Q. In taking those steps, in partially delivering the living fetus to a point past the umbilicus, would your purpose be to enable yourself to take steps that you know will kill the fetus?

A. Well, my purpose is to evacuate the uterus and complete the procedure. It's not specifically to do those portions of the procedure you described.

Q. Doctor, you mentioned that you were concerned that some of the induction termination procedures that

you perform could come within the scope of this ban, is that correct?

[641]

A. That is correct.

Q. Can you explain how that could happen?

A. Well, I can certainly describe some scenarios which could potentially trip the ban.

Let's say that you had initiated an induction procedure. Keep in mind that an induction procedure is not a, quote unquote, natural event, it is a deliberate and intentional act with the prospect, eventually, of a vaginal delivery.

But let's say that the fetus starts to deliver but delivers such that the calvarium, the head, is entrapped behind the cervix. That isn't a preposterous kind of assumption or scenario because if you were inducing, let's say an infant with hydrocephalous or any kind of enlargement or disproportion of the head and the rest of the body, the head is the largest part and could get stuck at the cervix.

Now, what do you do under those circumstances? Well, this kind of scenario could result in an obstetrician who really has had—has tried in good faith not to violate what they might perceive this ban to be to now have to try to assist the patient in completing this process.

And what we usually would do is analogous to a D&E. It's one of the reasons why the National Abortion Federation clinical policy guidelines are if you do a medical induction abortion you are supposed to have the instruments for D&E on [642] hand also in case you get stuck and have to finish the procedure surgically.

But let's say that the person doing the procedure didn't know how to, with the entrapped calvarium, with the entrapped head to reach up, perform a decompression procedure and complete the process as I have already described. Well, they might, in the process of trying to even just do a delivery, do an act which could be interpreted as the overt act.

Let's say they try to deliver a 20 week gestation where the neck is simply not as stable as what you might think with a full-term baby. We've had cases where people have—we being at Northwestern where people have attempted to do these deliveries and have evulsed, they have basically torn a great deal of the neck if not tearing it off just trying to deliver the rest of the baby.

And so, in that case that person could have violated the Act because they know the fetus isn't going to survive that act.

Q. Doctor, in that example what would have to be done in order to then deliver the fetal head?

A. Well, you would have to do it instrumentally, just like we do for a D&E. You need to reach in with one of the forceps that we use and do an act that would collapse the calvarium.

[643]

Now, again, because we have been talking about collapsing the head in many ways that doesn't always involve putting scissors in and, certainly, if it has been disarticulated we wouldn't do that. We would reach in with our forceps and take the head out.

Q. And in order to do that you would have to collapse the head?

A. Oh, you always have to collapse the head with the D&E procedures to get the head out.

Q. In every D&E?

A. That's correct.

Q. Doctor, in performing an intact D&E, do you deliver the fetus to a certain point for the purpose of performing an act that you know will kill the fetus?

A. No, I—in any D&E, including intacts, I deliver the fetus as intact as possible to get the operation over with.

Q. Doctor, in the induction example that you gave us where the head got stuck and you needed to proceed in the same way that you might with an intact D&E, are the steps that you take deliberate and intentional?

A. Yes, they are.

Q. And, in that scenario, do you deliberately and intentionally vaginally deliver the fetus?

A. Yes, I do.

Q. And what is the deliberate and intentional act that begins [644] the delivery of the fetus into the vagina in an induction?

A. Giving the medicine that starts the delivery process.

Q. Do you deliberately and intentionally deliver the fetus to a point past the navel?

A. In many cases, yes, because the uterus itself is going to start that process and effect that delivery. And if it's incomplete we are going to have to help the delivery process continue.

Q. And what would the overt act be, in that scenario?

A. It could be, in the scenario where you described where the fetus becomes stuck, it could be any act that can result in the demise as I extricate the baby, anything from disarticulating at the neck to collapsing the calvarium and so forth.

Q. Do you deliberately and intentionally perform the overt act in this situation?

A. Every act that I do in most abortions is deliberate and intentional.

Q. Doctor, we talked a little bit ago about the PPROM situation and your view that the Act could cover certain situations where you are treating patients who present with PPROM, is that correct?

A. That is correct.

Q. In those situations, is the fetus still alive in a PPROM situation when the patient first appears with ruptured membranes?

[645]

A. In the majority of cases there are cases where the fetus dies thereafter because of lack of fluid, but in the majority of cases the fetus is—in the majority of cases the fetus is still alive.

Q. And then the steps you would take would be akin to those of a D&E?

A. It is a D&E.

Q. Doctor, would you attempt to remove that fetus as intact as possible?

A. Absolutely. Just as with any other D&E.

Q. Why?

A. Because I think it's safer for the patient.

Q. Doctor, you gave us an example earlier, I think in response to one of the Court's questions, about how even cutting the fetal umbilical cord could be an overt act under the statute; is that correct?

A. That is correct.

THE COURT: I don't think the Court phrased it that way.

MS. CHAITEN: I was referring to the Doctor's testimony, your Honor, not just that it was in response to one of the Court's questions.

THE COURT: I think he was already talking about that but I don't think it was phrased in the Court's question that way, so why don't you rephrase that.

* * * * *

[649]

Q. Doctor, in the case where the cord obstructs delivery, could you push the fetus back up into the uterus so that the umbilicus is not outside the body of the mother and then grasp the cord and cut it in order to avoid the effect of the ban?

A. No, that—

MS. GOWAN: Objection, leading.

THE COURT: I will allow it.

The answer, yes or no.

THE WITNESS: No, I could not do that.

BY MS. CHAITEN:

Q. Why not?

A. It would be extraordinarily unsafe to the patient.

Q. Doctor, in the scenario you described as cutting the cord, does cutting the cord free it?

A. No, it doesn't.

Q. What is the purpose in cutting the cord?

A. To give me more room to try to continue to effect as intact a delivery as possible.

Q. Are all of the steps that you have taken in the scenario deliberate and intentional?

A. Yes, they are.

MS. CHAITEN: Your Honor, if I might just have one minute?

THE COURT: You may.

MS. CHAITEN: Your Honor, I have no more questions at * * *.

* * * * *

[656]

[Dr. Cassing Hammond—Cross]

Q. Now, you also testified on direct that you refer residents and fellows to the book, a Clinician's Guide to Medical and Surgical Abortion, correct?

A. That is correct.

Q. And that's a textbook developed by the plaintiff in this case, National Abortion Federation; isn't that right?

A. That is correct.

Q. And the lead editor in that book is Dr. Maureen Paul, right?

A. That is correct.

Q. And Dr. Paul is testifying as an expert witness in the challenge to the Partial-Birth Abortion Ban Act of 2003 that is pending right now in San Francisco, California, isn't that right?

A. That is correct.

Q. And you have sought, as a plaintiff in this case, to bring before Judge Casey, some deposition testimony of Dr. Paul in that case, correct?

A. I'm uncertain.

My attorneys may have done so. I don't know if we have sought to bring her deposition forward or not.

Q. Yesterday, in response to Judge Casey's questions, you were testifying about what you tell your patients when you give them informed consent, right?

A. Yes.

[657]

Q. And you told the Judge that you explained to your patients what happens during the course of an intact D&E, didn't you?

A. Yes, we do.

Q. And you told the Judge that you explained to your patients what compressing the head means, correct?

A. Yes, we do.

Q. But in fact, you don't explain to every patient that there is a possibility that you might remove the fetus intact up to the point where the head is stuck in

the internal cervical os and you perform a procedure to compress the skull or puncture the skull, do you, Doctor?

A. Not to every patient, no.

Q. You only do it if the patient asks you, isn't that right, Doctor?

A. In some cases, yes.

Q. Directing your attention to page 232, line 4 of the deposition that you gave in this case:

"Q Do you tell patients of the possibility that you may be removing the fetus intact up to the point where the head is stuck in the internal cervical os and then you perform a procedure to puncture the skull and aspirate the contents?

"A As I just stated, there are some patients who need more information than others. Most patients don't want to know specifics of the procedure, just as most patients who come in for a hysterectomy don't want to know the names of the [658] clasps or the procedure I used to dilate the uterine field or what I will do if we have a ureter that's located close to the uterus, just as most patients don't want to know the exact method that I use to crush or coagulate the uterine tube if we are doing a tubal ligation.

"So, in answer to your question, do I say this to every patient? No. But, if there was a patient who came in with specific questions and said, 'Well, what do you do if you're dilated enough and you extract to this or that point?' We would share that information with the patient." Were you asked those questions and did you give those answers at your deposition in this case?

A. Yes, I did.

Q. And in fact, Dr. Hammond, no patient has ever asked you, has she?

A. I don't know. Somebody might have. I don't have an independent recollection at this point.

Q. Directing your attention to page 233, line 4, of your deposition in this case:

"Q Has a patient ever asked that?

"A Not to my knowledge, no." The closest—

THE COURT: Wait. Let's finish the question.

Was he asked the question and did he give the answer?

MS. GOWAN: Doctor?

[659]

THE COURT: Did you?

THE WITNESS: Am I—

THE COURT: Is that?

THE WITNESS: That's—if you are reading from my deposition then, yes, that was my testimony.

BY MS. GOWAN:

Q. In fact, the closest you have ever come to having this kind of conversation with any of your patients is when they've come in and they've said to you, Doctor, is the procedure similar to what we've been hearing about in the media as being encompassed by the Partial-Birth Abortion Ban Act of 2003 or a similar statute; isn't that right, Doctor?

A. That is true.

Q. And your answer to them is, I'm not sure. There are a lot of problems with the legislation but that you

will do whatever is necessarily encompassed by the D&E to effect the procedure safely.

Isn't that right, Doctor?

A. That is correct.

Q. Now, my—

THE COURT: That's what you tell patients?

THE WITNESS: Well, the question was what I tell patients if they ask is this—

THE COURT: I heard the whole question and that is your response you give them?

[660]

THE WITNESS: It's part of my response and they will occasionally ask me, Well, what exactly are you doing?

Do you—how intact do you extract?

And we will have a relatively graphic conversation, your Honor, with those patients, and we will tell them exactly the kind of things that I spoke about earlier this morning on the direct examination.

So, if they choose to pursue this in any way or bring it up, we will have this conversation with our patients.

THE COURT: With the technical language that you used here?

THE WITNESS: No, no, no, no. With patients I make the most, the best attempt I can not to use words like calvarium and to replace it with skull and so forth. But we don't—we don't sugar coat it too much, your Honor.

THE COURT: You use reduction rather than crushing the skull?

THE WITNESS: I will say crush, clamp and extract, and I use those very words because those are what patients understand. We want them to know exactly what the procedure is going to entail. And we actually try not to sugar coat this for them because they're the ones who are going to undergo the procedure.

THE COURT: But only if they ask.

[661]

THE WITNESS: No.

Occasionally, a patient clearly wants more information and if we sense that, we try to give what's appropriate to the patient.

Keep in mind, a lot of my patients are emotionally quite fragile so we don't have to bring up the terms— we don't have to go into gory detail about everything that we are doing. But does that mean that we don't share with them that this involves dismemberment or separation of parts of the fetus or taking the fetus apart? We do. And we use that term. We say we take the fetus apart. We say, it is coming out in pieces. And we make sure that that's clear with the patients and they understand it. And given the circumstances that they confront and their alternatives, the majority of them want us to do the procedure.

THE COURT: Do you tell them whether or not it hurts the baby?

THE WITNESS: We have that conversation quite a bit with patients, your Honor.

THE COURT: And what's your answer?

THE WITNESS: We say several things to the patient, your Honor.

First of all, we tell the patient that it's * * *.

* * * * *

[671]

THE COURT: Oh, all right.

THE WITNESS: Can I just hear the question again? Because I am confused.

THE COURT: Ms. Reporter, do you want to read the question, please?

(Record read)

THE WITNESS: The fetal tissue tears more easily in gestation than later in gestation.

BY MS. GOWAN:

Q. What about at 20 weeks? Does the tissue of the fetus tear more easily at 20 weeks than at 24 weeks?

A. That is correct.

Q. And then, D&E by dismemberment, you routinely count all the fetal parts after the procedure is over, right?

A. We don't count all of the fetal parts, no.

Q. Doctor, don't you make an effort, when you perform D&E by dismemberment, to count the fetal parts after the procedure is over?

A. No. We look for sentinel parts. We look for certain things as well as the total amount to get an idea in conjunction with the feeling that we have, based on

the uterine feel, to tell whether we have performed a complete evacuation.

But we don't count every single part that we've extracted after one of these procedures; no.

[672]

Q. Well, you make an effort to count the four extremities and the head, don't you?

A. That we do, yes.

THE COURT: What are sentinel parts?

THE WITNESS: I am usually speaking with sentinel parts about four extremities and calvarium. I'm not trying to be elusive, but some of our fetuses don't have these so we are basically trying to look and make sure that we have accounted for the majority of the fetus looking for major parts.

But we don't count every single thing that we have extracted.

BY MS. GOWAN:

Q. You don't put the number in information in your operative note because it is assumed that if have you completed a D&E you have counted the extremities and the head, isn't that right?

A. That is correct.

Q. But if you haven't been able to retrieve all of the four extremities or what appears to be all of the fetal head, you will often put in your operative note the fact that you did an ultrasound after the procedure to confirm that you took that extra measure to confirm evacuation, right?

A. That is correct.

Q. Now, at 20 to 24 weeks you typically place between two to three sets of laminaria prior to D&E, correct?

* * * * *

[675] and grasped the fetus' head and, by compression, extracted it, right?

A. That is correct.

Q. You have also had the occasion, when performing a D&E at 20 to 24 weeks, to reach inside a woman with instruments and pull out a live fetus up to the point where the fetus' head gets stuck in the internal cervical os, correct?

A. That is correct.

Q. And when you do that that's not an accident, is it?

A. If you're—I want to make sure I understand. As I testified, every action I do is deliberate and intentional so it's not an accident that I have achieved the extraction to that point. It's not predictable either because I never know apriori if I am going to be able to achieve that intact a delivery.

Q. Was it an accident when you have done that, was it?

A. Well, it's not predictable so in that sense it is anaccident that I have been able to. It's still a deliberate and intentional act that I want to have occur so it's something I have been attempting to do.

Q. And you will do so if you can, right, Doctor?

A. Yes, that is correct.

Q. And you do that at least three times a month in your practice, don't you?

A. That is correct.

* * * * *

[678]

A. That is correct.

Q. And there isn't any scientific data to support your theory that more passes of instruments increase maternal risk, is there, Doctor?

A. No.

Q. And you don't even keep track of the number of passes that you make with instruments in any given procedure in the woman's medical record, do you?

A. That is correct, we do not.

Q. You couldn't even tell me how many passes with instruments you made in those cases in which you managed to pull a living fetus from a woman's uterus up to the point where the fetal head was stuck in the internal cervical os, could you, Doctor?

A. No, I could not.

Q. It's entirely possible that you could use more than one instrument pass to bring a live intact fetus out of the woman's uterus up to the point where its head gets stuck in the cervical os, correct?

A. That is correct.

Q. You could grasp a presenting part then realize that you have the fetus in an intact position. You could let go, regrasp higher on the fetus, right?

A. That is correct.

Q. You could grasp the presenting part, realize that you have a potential intact extraction, that you are not using the best * * *.

* * * * *

[684]

AFTERNOON SESSION

2:00 p.m.

CASSING HAMMOND, resumed.

THE COURT: Good afternoon.

CROSS-EXAMINATION (continued)

BY MS. GOWAN:

Q. Before the break, Doctor, we were talking about the comparison between the risk associated with puncturing the fetal skull and the risk associated with another pass of the instrument. I understand that it is your opinion that neither one of those poises a significant maternal risk, right?

A. That is correct.

Q. Is it fair to say that you want to be the decision-maker, you want to be the one to have the ability to decide whether you should make another pass with an instrument in connection with performing D&E, or whether you should be able to puncture the fetus's skull?

A. I want to do what is safest for my patient.

Q. Is that a yes or a no, Doctor?

A. I think it is a yes.

THE COURT: There isn't any question, is there? Let's not pussyfoot.

Q. Counsel asked you to assume, in connection with your review of Congress's finding on cervical incompetence, she asked you to assume that the finding related to intact D&E, and you [685] testified that there was data that would support that in fact there was no evidence of cervical incompetence in connection with intact D&E. What data were you referring to?

A. I was referring to the article by Schneider, et al., from the mid nineties—Schneider and Caspi, I think, C-A-S-P-I, are two of the authors—that has looked at the dilatation of the internal os, or opening of the cervix, after second trimester and first trimester abortions, and has also looked at obstetrical outcome after second trimester abortions.

Q. That article and the data underlying that article does not deal specifically with intact D&E, does it?

A. It deals with D&E. Correct, they don't specify intact D&E.

Q. And you are not aware of any specific data that does break out or address the safety of instrumental or digital fetal conversion in connection with the performance of intact D&E, right?

A. I believe that is a part of every D&E, so I believe that it is covered by any studies of D&E.

Q. You are not aware of any that specifically breaks it out.

You assumed in your response to counsel's question the fact of intact D&E. I am merely asking you to assume intact D&E and whether there is any specific data that breaks that out in connection with addressing safety of instrumental or digital fetal conversion.

A. I know of no data that specifically breaks out instrumental [686] conversation with respect to intact D & E.

Q. Occasionally when you perform D & E you convert a fetus to the breech position, don't you?

A. When I perform a D & E, that's correct, yes.

Q. You have testified that you think intact D & E offers advantages because less passes with instruments present fewer chances of perforation of the uterus, less procedure time, and less blood loss, right?

A. That is correct.

Q. In your opinion, uterine perforaton is so uncommon that it canot even be used as a end point for a study, isn't that right?

A. I believe it can be usd as an end point for a study, but it would be difficult, because you have so many cases to achieve statistical power that it would be a very lengthy and difficult study to perform.

THE COURT: While we are waiting, Doctor, why don't you define an end point study.

THE WITNESS: The end point would be a criteria or variable that represents outcome. So in evaluating D & E, examples of end points could be rate of uterine perforation, could be rate of hemmorrhage, typically defined by the number of patients who require blood transfusion, the number of patients who have clinically significant infections which they might define based on a temperature that a patient developes, and so * * *.

* * * * *

[689]

Q. That would be regardless of the number of instrument passes, correct?

A. Yes.

Q. In the majority of induction labor abortions, the physician attempts to have the placenta delivered spontaneously, much as you would after a term delivery of a child without instrumental delivery, correct?

A. That is correct.

Q. I know you testified previously about the two-hour interval between the delivery and induction abortion and the expelling of the placenta that is often provided. Are you aware that today some medical institutions wait two hours for delivery of the placenta after the fetus is expelled in an induction abortion?

A. Yes, there are some places where that occurs.

Q. One of those, are you aware, is where your co-plaintiff Dr. Johnson practices, at the University of Michigan?

A. I was not aware that that was the case at the University of Michigan, but it may well be so.

Q. Whether there is spontaneous delivery of the placenta also varies with the induction agent that is used, isn't that right?

A. I believe that is the case.

Q. I think you mentioned earlier today dinoprostone?

A. That is correct.

Q. Most of the available data on the time frame relates to [690] dinoprostone, is that correct?

A. That's correct.

Q. That is dated from the 1980s, is that right?

A. The seventies as well as the eighties, that is correct.

Q. There isn't much data yet with regard misoprostol in induction abortion, is there?

A. With regard to retained placenta?

Q. Correct.

A. No, there is not.

Q. In a D&E by disarticulation and in an intact D&E, there is always surgical instrumental removal of the placenta, correct?

A. That is correct.

Q. You would agree, wouldn't you, Doctor, that there isn't any data substantiating that D&E is safer than abortion by medical induction at 20 to 24 weeks?

A. I agree that the risks are similar between 20 and 24 weeks.

There is some data suggesting a slight preference of D&E, but there is also data suggesting a slight preference for medical induction. So it is unclear between 20 and 24 weeks, particularly for every practitioner, which is the safer method of terminating pregnancies.

Q. You assume in your hands, meaning in your practice, that D&E between 20 and 24 weeks is only at least as safe as induction labor abortion, correct?

A. I assume that it is at least as safe and probably safer.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

Mar. 29, 2004

REPORTER'S TRANSCRIPT OF PROCEEDINGS

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* * * * *

[Dr. Maureen Paul—Direct]

[15] your opinion, a normally-developed fetus is likely to become viable?

A. About 24 weeks.

Q. And is that lmp?

A. Yes.

Q. And throughout your testimony, when you refer to the number of weeks, are you referring to that number of weeks lmp?

A. Yes.

THE COURT: Could I ask a question? Is lmp the first day or last day of the menstrual period?

THE WITNESS: The first day of the last menstrual period, your honor.

BY MS. GARTNER:

Q. Dr. Paul, does pregnancy ever cause serious medical conditions for the pregnant woman?

A. Yes.

Q. Can you give me some examples of those?

A. Yes. There are conditions that are specific to pregnancy. One example is a condition called "preeclampsia," which is a condition that affects many of the systems of the body. It presents as high-blood pressure, and protein in the urine. But it can also include abnormalities of the liver, abnormalities of the blood-clotting system.

And it can progress to seizures, in which case the condition is called "eclampsia." There are infections that are [16] specific to pregnancy like chorioamnionitis, which is an infection of the uterus that occurs only during pregnancy.

And then there are conditions that can happen in nonpregnant women, but are more likely to happen in pregnant women. And an example of that would be the propensity to have blood clots, either in the lower extremities or in the lungs. And that is called thromboembolism and pulmonary embolus.

Q. These conditions, these examples you have given of preeclampsia, chorioamnionitis and the blood clots, when in pregnancy are these conditions likely to occur?

A. Preeclampsia and chorioamnionitis are more likely to occur in the second and third-trimester. Blood clots can occur any time.

Q. And what about in women that are already unhealthy in some respect, can pregnancy ever make their underlying medical conditions worse?

A. Absolutely.

Q. Can you give me some examples of that?

A. Yes. Pregnancy entails many changes that happen in the body that can be tolerated by normal women, who are normal and healthy, but can be very taxing to women who have underlying medical conditions.

An example might be heart conditions. For instance, the blood volume in pregnancy nearly doubles. The heart rate goes up.

|17|

Q. Let me just stop you there. You are talking about the blood volume of the pregnant woman?

A. The blood volume of the pregnant woman, that's right. The amount of blood in the system nearly doubles during pregnancy, and the heart rate goes up. The amount of blood that is coming through the heart and that has to go out to feed the tissues is therefore greater. And the heart is working harder. So that if you have a woman who has a heart condition, this can be very taxing.

It can cause increased pressures in the heart that can backup into the lungs and you can get things called "pulmonary edema," that is fluid in the lungs or heart failure. Another example would be diabetes. There are hormonal changes that happen in pregnancy that can make it very difficult to control the blood sugars in a diabetic so that you can get dangerously low blood sugars leading to seizures, or you can get dangerously high blood sugars, which can result in coma. So those are a couple of examples.

Q. Is there a particular time in pregnancy when such underlying medical conditions tend to worsen?

A. They tend to worsen as pregnancy progresses.

Q. And, Dr. Paul, have you treated patients in your medical practice with all of the types of conditions that we've just discussed who have chosen to end their pregnancies because of those conditions?

[18]

A. Yes, and others.

Q. Have you treated patients who have chosen to end their pregnancy because the fetus is diagnosed as having a serious anomaly?

A. Yes.

Q. Can you give me some examples of those from your medical practice?

A. Basically two types: one is chromosomal anomalies.

Q. Why don't you tell us what is a chromosomal anomaly?

A. The chromosomes are basically packages of genetic material, so it is genetic types of defects. You

can have too many chromosomes, too few chromosomes or chromosomes that have structural defects. And I have treated women who have had all of those types of chromosomal anomalies.

The other thing is just anomalies of the fetus that are structural anomalies so that they are visible birth defects.

Q. Can you give me one or two examples of those?

A. Heart defects, or there is a neural tube defects that are defects of the spinal cord or brain.

Q. Have you treated patients with those sorts of fetal anomalies that have chosen to end their pregnancies?

A. Yes.

Q. And at what gestational ages are abortions for fetal anomalies generally performed?

[19]

A. Generally after the first-trimester.

Q. And why is that?

A. Because we often can't diagnose these anomalies until after the first-trimester. There may be abnormalities that appear on an ultrasound that just don't appear until the second or third-trimester, and that is when we first attack the anomaly. And there is also genetic tests that can only be done in second-trimester.

Q. Dr. Paul, can you just describe briefly what is "ultrasound"?

A. "Ultrasound" is using sound waves in order to visualize the pregnancy.

Q. And is there a general time in pregnancy when women routinely have an ultrasound?

A. It is very common for women to have ultrasound during pregnancy, and most commonly in the second-trimester, maybe 13 to 20 weeks. If there is any question about dating, it could occur earlier, or there could be a second ultrasound or even a third ultrasound that is done.

The earlier in a pregnancy that you do the ultrasound, the better it is for the dating purposes. But you really need to do it a little bit later in the second-trimester if you are going to look for anomalies and things like that.

Q. When you say "dating," you mean to determine the gestational age of the fetus; is that right?

* * * * *

[44]

Q. And can you describe briefly what vacuum aspiration abortion is?

A. It is using a source of suction to evacuate the uterus. It can be manual vacuum aspiration, just a syringe-like device that we use to create the suction, or it can be an electric pump that creates the suction.

Q. And what methods of abortion are available in the second-trimester of pregnancy?

A. D&E abortion, dilation and evacuation, which can occur either through disarticulation or as an intact procedure. And there is induction abortion, which is basically giving medications to cause labor contractions to have the woman expel the fetus.

Q. And, Dr. Paul, is there a particular term that you use to describe D&E's that occur by intact extraction?

A. I say the word "intact" D&E. I think it is really just a variant of D&E, so I wouldn't necessarily always identify them separately.

In the textbook when we have a section on it we refer to it as "intact D&E."

Q. And when you say "the textbook," are you referring to your "a Clinician's Guide to Medical and Surgical Abortion"?

A. Yes, I am.

Q. Dr. Paul, if you know, do some doctors use the term D&X to describe abortions in which the fetus is removed with intact [45] extraction?

A. I have seen that used in various ways. I mean, I have heard physicians use it generically to be pretty synonymous with intact D&E.

I do know that ACOG had a specific definition in a publication that it had described something that was much more specific, but I find that it is not really uniform the way that people use that term.

Q. Dr. Paul, when you say "ACOG," is that the American College of Obstetricians and Gynecologists?

A. Yes, it is.

Q. In your opinion, are intact D&E or D&X a distinct procedure from D&E?

A. Not in my opinion. I consider them a variance of D&E.

Q. Dr. Paul, where are most—where are most D&E procedures performed?

A. In clinics.

Q. And is that an outpatient type setting?

A. Yes, a nonhospital-based outpatient clinic.

Q. And where are most induction abortions performed?

A. In hospitals.

Q. And why is that?

A. Well, induction abortion involves giving medications to put a woman into labor, which can happen over several hours, sometimes even takes a day or two. So —and there are some * * *.

* * * * *

[47] are about 0.01 percent of all abortions and about 0.07 percent of second-trimester abortions.

Q. Dr. Paul, are there data showing what percentage of abortions are performed by each available method at particular gestational ages?

A. Yes.

Q. And who collects that data?

A. The CDC.

Q. And is that part of the CDC abortion surveillance document that we were just looking at?

A. Yes, it is.

Q. Dr. Paul, if you would like to turn back to exhibit 7, which you should have there still to page 32.

Is table 18 on page 32 the data that you are referring to?

A. Yes.

Q. Can you explain the information that is contained in this table, please?

A. Yes. Title is "reported legal abortions by known weeks of gestation and type of procedure."

And on the left-hand column here is the type of procedure. Across the rows we have the gestational ages increasing from left to right. And then, the data is in the rest of the table.

Q. And what is meant on this table? I'm looking at the [48] left-hand column, it says:

"Intrauterine saline instillation, intrauterine prostaglandin instillation and medical." What procedure do those refer to?

A. Those are different methods of induction abortion that were used at the time.

Q. And that all three of those are induction abortions?

A. Yes, they are.

Q. And where—

A. Although, I—yes, that's right. There is a footnote in this table that indicates that "medical" involves primarily the use of vaginal prostaglandins, which is a method for use to induce an induction abortion.

Q. And where in this table are data for D&E reflected?

A. Under "curettage." So the D&E's would be the curette abortions that were done at 13 weeks or greater. So, that's how the CDC categorizes them.

Q. And are data for intact D&E abortions reflected in this table?

A. Not separately. But as I said, intact D&E is a variant of D&E, so I strongly suspect that there are intact D&E's that are included in this—these data, as well as D&E's that proceed by disarticulation.

Q. Looking at these data for 16 to 20 weeks gestation, what percentage of abortions were done by D&E versus what percent [49] for inductions?

A. At 16 to 20 weeks gestation about 95 percent were done by D&E.

Q. Is that—I am sorry. Just to be clear. It is a little hard to read. Are you there pointing to the number of 94.6?

A. 94.6, yes. This 16 to 20; is that what you are asking?

Q. Yes.

A. So 94.6, which I am rounding off to 95 percent. About 95 percent were done by D&E abortion, and about 5 percent by induction.

Q. And then, looking at these data with respect to all abortions after 20 weeks gestation, the same question: what percentage of women had D&E versus what percent had induction abortions?

A. Those data are right here. About 85 percent had D&E abortion, and about 15 percent had induction abortion at 21 weeks or greater.

Q. Dr. Paul, we have gone through a lot of background information, but now I would like to focus in on the particular methods of abortion that would, in your opinion, be affected by the law at issue in this case.

So why don't we identify what those are? In your opinion, would any of the first-trimester methods that you described ever be affected by this law?

A. Not in my opinion.

[50]

Q. And in your opinion, would hysterotomy or hysterectomy abortions every be affected by this law?

A. No.

Q. In your opinion, would the D&E method ever be affected by this law?

A. Yes.

Q. And in your opinion, would the induction method ever be affected by this law?

A. It could be.

Q. Why don't we start by talking about the D&E abortions? What I would like you to do is to explain in greater detail how you perform a D&E. And start with telling us in general what are the primary components involved in a D&E abortion?

A. There are two primary components. One is cervical preparation, and the other is evacuation of the uterus.

MS. GARTNER: Your honor, with your permission we have some charts or diagrams that may be helpful. Thank you. Your honor, are those placed in a way that you can see it?

THE COURT: I can see it.

THE WITNESS: May I step down, your honor—

THE COURT: Sure.

THE WITNESS: —If I need to?

BY MS. GARTNER:

Q. Dr. Paul, what I would like you to do is explain to the [51] court why it is necessary to prepare the cervix for a D&E abortion. And if it is helpful to you, you know, feel free to use one of these diagrams.

A. I think I will use this diagram over here to illustrate that. This is the uterus (indicating). The uterus—as you can see, this is a nonpregnant uterus. It is a pear-shaped organ, and it has a narrowing that happens down here at the neck. That is called the cervix.

The cervix has some length. There is something called the external os, which is the external opening that's right at the top of the vagina.

And then, there is the internal os, which is at the other end of the cervix.

Q. And what is the distance, on average, between the internal os and the external os?

A. It certainly can vary, and especially during pregnancy. But it can be as much as 3 inches. It can be as little as 1 inch.

Q. And I am sorry to interrupt you. And then, what is it—if you can explain to us why the cervix needs to be prepared for the D&E abortion.

A. So the cervix is normally closed. It's the entrance into the uterus where the pregnancy is. And our goal in doing any abortion is to get something larger, which is the fetus, out of something smaller, which is the cervix, without causing injury [52] to the cervix.

So in order to do that, it's necessary to prepare the cervix before you try to bring out the fetus. And

that means to dilate the cervix, soften the cervix, get it ready, basically, for the evacuation.

Q. Thank you.

You mentioned two things: dilating the cervix and softening the cervix. What are the ways that you use to dilate the cervix?

A. I would say that there are ways that I use to prepare the cervix, because each method will do some dilation and some softening. So it is kind of a blurring of those, so I just want to be clear about what i am saying. And that is: what are the methods that i use to prepare the cervix?

One of them is the use of osmotic dilators, and the other is the use of medications to prepare the cervix.

Q. Thank you for that clarification. Why don't we talk first about the osmotic dilators. Can you explain what that term means?

A. An osmotic dilator is a short stick of compressed seaweed or synthetic material that is placed into the cervix. It absorbs fluid from the cervix and vagina, and expands, kind of like a dried piece of seaweed on the beach expands when it gets wet and gradually stretches the cervix open.

MS. GARTNER: Your honor, I have a laminaria. Would [53] you object if I handed it to Dr. Paul?

THE COURT: Sure.

BY MS. GARTNER:

Q. Dr. Paul, is that a laminaria?

A. Yes, it is.

THE COURT: Laminaria being what? May I see it?

THE WITNESS: So this is an example of a laminaria. It's one type of osmotic dilator. It is made of compressed seaweed.

BY MS. GARTNER:

Q. And do laminaria come in different sizes?

A. Yes.

Q. And what size is this one?

A. This is a large.

Q. And when you say—when you say "they come in different sizes," do they come in different lengths and different widths or—

A. Different widths.

Q. Can you describe how you insert the laminaria into the woman's cervix?

A. Yes. First I do an examination, get an idea of—just to be sure that things are fine in terms of the size of the uterus, the position of the uterus, where the cervix is located in relation to the vagina. I then insert a speculum, which is what we use when we do pap smears and general gynecological [54] exams to visualize cervix, so it is a small instrument that we put into the vagina and open up, and the cervix comes into view.

I then wipe off the cervix with an antiseptic solution. And sometimes I will put a little numbing medicine around the cervix to make the insertion more comfortable. I then use an instrument to grasp the laminaria, and I put the laminaria into the canal. So I am putting it through that external os and up the canal and into that—just a little passed that internal os.

Q. And I think you may have said this, but what is it about the laminaria that causes dilation?

A. They absorb fluid and expand and stretch the uterus, the cervix open.

Q. And how many laminaria do you use?

A. As many as will comfortably fit without forcing.

Q. And does that number vary by the gestational age of the pregnancy?

A. Well, I have minimum criteria by gestational age. So that, you know, it is important, for instance, at 14 to 16 weeks gestation, I would want at least two large laminaria. At 16 to 17, a minimum of three. And then, at 17 to 18, six, a minimum of four. But I really want to emphasize the minimum, because in my opinion the more you can get comfortably in without forcing the better.

[55]

Q. Okay. And do you ever do a second insertion of laminaria for one patient?

A. Very rarely.

Q. And how long do you leave the laminaria in place before you begin the evacuation part of the procedure?

A. It can vary, again, by gestational age, but generally at 16 weeks and over we leave the laminaria in overnight.

Q. And can you predict the amount of dilation you will achieve with the laminaria?

A. No.

Q. Why is that?

A. Because women cervixes just differ, and there is just great variability in the amount of dilation you can get in different women, given the same number of laminaria inserted.

Q. And how do you determine if the dilation that you've achieved is sufficient to continue with the procedure?

A. I need enough dilation to get the instruments in that I use and to have some extra mobility to be able to move those instruments.

So the instruments that I use on the gestational ages I do are 16 to 17 millimeters in diameter. So I am going to want, you know, 18 or more millimeters as a ballpark.

Q. In your opinion, in doing a D&E, is it possible to achieve too much cervical dilation?

A. Not in my opinion.

* * * * *

[57]

BY MS. GARTNER:

Q. Dr. Paul, I think I had just asked you whether in doing D&E abortions and preparing the cervix if it is ever possible to achieve too much cervical dilation, in your opinion?

A. Not in my opinion.

Q. And why is that?

A. Because the more dilation that I have, the easier the evacuation is, and usually the faster, too.

Q. If dilation is so beneficial, why don't you routinely dilate more than you do now?

A. Well, I already said that I put in as many laminaria as I can that will comfortably fit without forcing. And that generally gives me the amount of dilation that I need to accomplish the abortion safely at the gestational ages that I do it.

If I am going to do more dilation, I would need to bring the patient back for a second set of dilator insertions, which would be—which would delay the abortion by 24 hours. And as you weigh kind of the factors it just doesn't make a lot of sense for the gestational ages that I do to do two sets of dilator insertions.

Q. And at what gestational age do you begin using overnight laminaria before the abortion?

A. Sixteen weeks.

[58]

Q. So, you said that osmotic dilation is one of the ways you prepare the cervix; is that right?

A. That's right.

Q. What are some of the other ways that you prepare the cervix for the evacuation?

A. The other main way is to use a medication called misoprostol?

Q. What is misoprostol?

A. It is a prostaglandin agent. And prostaglandin agents can cause some contractions, and they also affect the substance of the cervix in a way that softens it.

Q. I don't know if you can describe briefly how that works.

A. You mean, how—how it works?

Q. Yes.

A. Well, the cervix is made up of fibers called "collagen fibers" that are kind of cross-linked, and it affects the fibers in a way that makes the cervix softer.

And it also causes contractions, of course, which helps to dilate and soften the cervix.

Q. And how is the misoprostol administered to the woman?

A. In various ways. It can be administered through the vagina, just placed into the—they are little white tablets that we place into the vagina. They can be swallowed. And they can be placed in the cheeks. That is called buccal administration, or under the tongue, which is sublingual [59] administration.

Q. And in your practice, how do you administer misoprostol?

A. Buccal administration.

Q. And just for the court reporter, could you spell "buccal," please?

A. B-u-c-c-a-l.

Q. And when in relation to the evacuation part of the procedure do you administer the misoprostol?

A. We generally administer it about 90 minutes before the abortion. There's a range. It can be 90 minutes to three hours.

Q. And do all women respond to cervical ripening with misoprostol in the same way?

A. No. Once again, there is a lot of variability in women's response to the cervical ripening.

Q. After you have given the woman the misoprostol, do you allow her to leave the health center?

A. No.

Q. Why is that?

A. Because women can get contractions and actually have a simultaneous abortion. They can actually miscarry, which we don't want to have happen at home. It has been reported in the literature if you use it the night before an abortion that women can actually expel a fetus at home, and we don't want that to happen.

[60]

Q. And, Dr. Paul, I think I should have asked you this before, but after you insert the laminaria when you are using laminaria in an overnight setting, after you have inserted the laminaria, can the woman leave the health center with the laminaria in place?

A. Yes. She can carry out her normal life.

Q. You said that the fetus, that the misoprostol can result in the fetus being expelled; is that correct?

A. That's correct.

Q. Does it sometimes happen that the fetus is completely expelled from the woman as a result of the misoprostol?

A. Yes, I have had that happen.

Q. Does it sometimes happen that the fetus is partially expelled from the uterus as a result of just the misoprostol?

MR. QUINLIVAN: Objection, leading, your honor.

THE COURT: Overruled.

THE WITNESS: Yes.

BY MS. GARTNER:

Q. When that happens, when the fetus is partially expelled, could a part of the fetus past the navel be outside of the uterus?

MR. QUINLIVAN: Objection.

THE WITNESS: Absolutely.

MR. QUINLIVAN: Objection, leading.

THE COURT: Overruled.

[61]

BY MS. GARTNER:

Q. Could a part of the fetus past the navel be outside the woman's body as a result of the misoprostol?

A. Yes.

Q. Could it be alive when that happens?

A. Yes.

Q. In that situation where the fetus is partly expelled simply as a result of the administration of misoprostol, how would you complete the procedure in that circumstance?

A. Well, I would apply traction and pull on the fetus to see if the whole fetus would deliver without any other kind of intervention. If the head was lodged at the internal os and couldn't come through, then I would disarticulate the neck, and then complete the procedure with my forceps, going in to get the calvarium, which is the head of the fetus.

Q. Dr. Paul, for how long have you been using misoprostol for cervical ripening before doing D&E abortions?

A. About three years.

Q. At what gestational ages do you use it?

A. I use it by itself usually between 14 weeks and the beginning of the 16th week. Sixteen to 17 weeks I tend to use overnight laminaria. And then, at 17 weeks and up, I tend to combine the methods, using both laminaria and misoprostol.

Q. So from 16 to 17 weeks you would tend to use only the laminaria; is that right?

[62]

A. Yes, it is like 16—throughout the 16th week. And then, once 17 weeks comes, I tend to use both. It can vary a little bit, depending on if the woman had a lot of deliveries in the past in which case I am going to have to dilate a little easier with my method. So, but, in general, those are my—the protocols that I follow.

Q. Dr. Paul, I would like you now to describe in detail the evacuation part of the D&E procedure. When the woman returns to your health center after the laminaria has been in place overnight or if she has only had the misoprostol, if the misoprostol has been in place for the requisite time period, please describe in detail what you do up to the point where you are going to extract the fetus.

A. I do a pelvic examination again. If she has laminaria, and sometimes I can remove the laminaria during that examination just with my hands.

Pelvic examination involves putting two fingers in the vagina, and the other hand on top of the woman's abdomen and kind of trying to assess, again, the size and position of the uterus, which is extremely important before you do a procedure.

So, when I have my fingers in the vagina sometimes I can just extract the laminaria at that time.

Q. Let me interrupt you. Can you describe what you mean by "the position of the uterus"?

* * * * *

[67] with a little tube attached to suction that breaks the bag and sucks out the fluid.

Q. And when you begin the evacuation, is the fetus ever alive?

A. Yes.

Q. How do you know that?

A. Because I do many of my procedures especially at 16 weeks under an ultrasound guidance, so I will see a heartbeat.

Q. Do you pay attention to that while you are doing the abortion?

A. Not particularly.

I just notice it sometimes.

Q. So after you've broken the bag of waters and the fluid is either drained or you've suctioned out the fluid, what do you do next?

A. I evacuate the fetus.

Q. And can you describe how you do that?

A. Yes. I do it using an instrument called forceps. So I insert the forceps and grasp the fetus and pull. That's all the while putting traction on the tenaculum to straighten out that angle. And sometimes the fetus comes out in pieces, and I make instrument passes until the entire fetus is evacuated. And sometimes the whole fetus will come down into the vagina, at least as far as the head.

Q. Okay. Does it ever come out completely without the head becoming lodged?

[68]

A. Rarely it does.

Q. And, in general, what is your objective in evacuating the uterus?

A. My objective is to empty the uterus in the safest way possible.

Q. Is there any advantage to doing the evacuation quickly?

A. Yes, quickly and safely is best. But if you can do the procedure expeditiously, there are some advantages, the biggest being that you have less bleeding and shorter duration of discomfort for the woman.

Q. Why is there less bleeding if the procedure takes less time? Where is the bleeding coming from?

A. Well, if the placenta has detached at all, then there is blood vessels there that can bleed. And the key thing is that the uterus can't contract well to seal off blood vessels and stop bleeding until it is empty.

Q. Okay. Talking now about the situations where the fetus comes out in parts, how many instrumental passes does it typically take to empty the uterus?

A. There is no typical. It could be as many as—as little as two or three or as many as 10 to 15.

Q. And do you have a goal for how many passes it will take?

A. As few as possible.

Q. And why is that your goal?

A. Because every time you pass a forceps into the uterus, [69] there is a small risk of injury.

Q. And can you explain how that would happen?

A. Yes. You can get a laceration of the cervix or a perforation or laceration of the uterine wall with the instruments.

Q. And would that still be a possibility if you were doing the procedure under ultrasound?

A. Yes.

Q. When the procedure goes in such a way that the fetus is drawn out in parts, how does the disarticulation of the fetal parts occur?

A. It occurs because you have the fetal part drawn outside of the cervix, and then there is a counter-pressure that occurs at the internal os. And when you pull, the—it disarticulates that part.

Q. So, is the part that is being disarticulated inside the uterus or outside of the uterus at the moment of disarticulation?

A. Outside.

Q. Can it be outside the woman's body?

A. Yes.

Q. And you had said that sometimes when you apply traction to the fetus it comes out intact up to point where the calvarium lodges; is that correct?

A. Yes.

[70]

Q. In that circumstance, what do you do to complete the procedure?

A. Well, there are two things you can do. You can disarticulate at the neck, or what I prefer to do is to just reach in with my forceps and collapse the skull and bring the fetus out intact.

Q. So when you—in the first scenario where you disarticulate, would you consider that to be an intact D&E?

A. No.

Q. Do you have a preference in your medical practice between D&E's that result in disarticulation and D&E's that result in intact extraction of the fetus?

A. I absolutely prefer intact extraction.

Q. Can you explain why that is?

A. Because it involves fewer instrument passes, and as I explained earlier, each instrument pass there is a small risk of injuring the uterus. And because it is faster, generally.

Q. When you are performing a D&E, when you are beginning to apply traction on the fetus to bring it out, do you take steps to try to keep the fetus as intact as possible?

A. If I know I have good dilation and I reach in and the fetus starts to come out and I think I can accom-

plish it, the abortion with an intact delivery, then I use my forceps a little bit differently. I don't close them quite so much, and I just gently draw the tissue out attempting to have an intact [71] delivery, if possible.

Q. Just to be clear about this, in those situations where you are able to bring it out intact, but the calvarium lodges at the os, why does it lodge there? Why can't you just extract the entire fetus?

A. It is the biggest part of the fetus. Sometimes the dilation isn't enough for it to come through.

Q. In your practice, Dr. Paul, how often do you perform D&E's involving intact delivery to the point where the calvarium lodges at the cervix?

A. I am guessing, because until this case happened I didn't pay much attention to it. It was just a variation of the way I did D&E. But I am guessing 1 to 10 to 1 to 20 maybe of the procedures I do.

Q. Of the D&E procedures?

A. Yes, of the D&E procedures.

Q. What determines whether the procedure will proceed with disarticulation versus whether there will be an intact extraction?

A. It's primarily the amount of dilation.

Q. And before beginning the procedure, can you predict if you will have enough dilation to bring the fetus out with an intact extraction?

A. No, I can't.

Q. But if you have enough dilation to do so, do you attempt [72] that?

A. Yes.

Q. Dr. Paul, you've said that the one of the reasons why you prefer the intact extraction is because of the reduction of instrumental passes; is that correct?

A. Yes, that's one reason.

Q. Are there other advantages in your opinion in bringing the fetus out intact?

A. I mentioned that it tends to be faster, and therefore you may have less bleeding and less discomfort for the patient.

Also, what I find advantageous is that I know I have removed the whole fetus. When you do a disarticulation D&E, you know, sometimes it is not as easy to tell that you have all of the parts. So, if I have an intact fetus, I know I have removed that entire pregnancy.

Q. What happens in a disarticulation D&E if some tissue actually does remain in the uterus?

A. You can get bleeding or infection.

Q. And do you think it is possible to leave some tissue in the uterus even if you are doing the procedure under ultrasound guidance?

A. I think it is possible to leave a small part or to leave part of the placenta.

Q. And would even a small piece of tissue or placenta result in possible complications?

[73]

A. Yes. I have always been surprised of how little it takes.

Q. Dr. Paul, how long does the evacuation part of the D&E take when the fetus is disarticulated in the process?

A. It really varies, but generally 10 to 15 minutes.

Q. And what is a typical length of the evacuation part of the procedure if the fetus remains intact?

A. It is usually much quicker. I have had it happen in a minute or two.

Q. In your medical practice, Dr. Paul, have you personally ever perforated a woman's uterus in the process of doing a D&E abortion?

A. Yes.

Q. And has it ever happened that you've perforated a woman's uterus in circumstances where you extracted the fetus intact or relatively intact?

A. It has only happened a couple of times, but it hasn't been—those two times was not associated with an intact extraction.

Q. You testified earlier, Dr. Paul, that the fetus can be alive when the evacuation begins; is that correct?

A. That's right.

Q. When in the course of the abortion does the fetus —does fetal demise occur?

A. I don't know for sure. I certainly know that if I deliver intact and collapse the skull that demise occurs.

[74]

Q. After the evacuation part of the procedure is complete, what do you do to complete the abortion?

A. I use suction to remove any placenta that may be left in the uterus. I also use an instrument called a

curette. It is a little spoon-like instrument just to gently go over the walls of the uterus and just be sure that anything feels—the uterus feels empty.

Q. Dr. Paul, I am going to ask you some questions about the impact of this law on your medical practice.

MS. GARTNER: And, your honor, we have a blowup of the act, if you don't mind.

THE COURT: Sure.

BY MS. GARTNER:

Q. Dr. Paul, this chart contains the operative portions of the law that is at issue in this case. Can you just briefly review it so you can recollect the language?

Dr. Paul, are you concerned about the potential impact of this law on your medical practice?

A. Absolutely.

Q. Can you outline your concerns for us?

A. Well, my overriding concern is that if I continue to practice abortion, second-trimester abortions, in the way I believe is the safest for women, that I could be in prison.

Q. In your opinion, could this law be understood as banning some of the D&E's that you do?

[75]

MR. QUINLIVAN: Your Honor, objection. It is our position that question of the interpretation of the law is not something that is subject to expert testimony. That is a subject that the Court will consider after arguments by both parties. But it is not something that is properly subject to an expert's opinion.

MS. GARTNER: Your Honor, I think it would be helpful—and obviously the final determination on this is your Honor's—but I think it would be helpful for Dr. Paul to explain how she used these terms and how she thinks that these terms, which are not necessarily clear on their face, would apply to her specific medical practice and how she does abortions.

THE COURT: I am going to permit it.

MS. GARTNER: Thank You.

BY MS. GARTNER:

Q. Dr. Paul, could this law be understood as banning some of the D&E's that you do?

A. Yes.

Q. If you look at the law, it states that:

> "The term 'partial-birth abortion' means an abortion in which the person performing the abortion deliberately and intentionally vaginally delivers a living fetus."

Do you see that language?

[76]

A. Yes.

Q. What does the term "vaginally delivers" mean to you as an OB/GYN?

A. "Vaginally delivers" means the fetus comes out through the vagina.

Q. And what does the term "living fetus" mean to you?

A. Well, "living" could be when there is a heartbeat detected on ultrasound, which could be as early as five

weeks gestation. "Fetus" usually applies to the products of conception at 10 weeks and up. So if I put the two together, I would say a fetus at 10 weeks gestation, or more, that has a heartbeat.

Q. And you said that the term "fetus" was used beginning at 10 weeks gestation; is that right?

A. Ten weeks lmp, yes. Before that the products of conception are known as an embryo.

Q. In your mind is the term "living fetus" equivalent to the term "viable fetus"?

A. Absolutely not.

Q. In the D&E's that you do, do you ever deliberately and intentionally vaginally deliver a living fetus as part of the procedure?

A. Yes.

Q. Dr. Paul, continuing reading in this definition, it says that—just to repeat what we have already gone over—that:

> "the abortion occurs such that the physician [77] deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother."

Do you see that?

A. Yes.

Q. When the law says that "any part of the fetal trunk past the navel" is outside the body of the mother, what do you understand that to mean?

A. Well, it could mean a couple of things. One is that the fetus has come out far enough that the fetal body above the navel is outside of the cervix. The other—outside the body of the mother. And the other is that if you were to disarticulate a fetal part that was above the navel, like a limb with part of a shoulder, I would think that that would also apply.

Q. So, just to be clear about that, as you read this law, does the fetus have to be delivered intact up to the point where the calvarium lodges at the cervix for a violation to occur?

A. No.

Q. Does it have to be brought out intact to any point for a violation to occur?

A. It has to be brought out—one scenario is that it's [78] brought out past the navel intact. And the other is that, as I say, to disarticulate a part above the navel, and then continue to put your forceps in to deliver the rest of the fetus.

Q. And in doing D&E's do you ever deliver the fetus to the point where part of the fetal trunk intact with the rest of it is outside the body of the mother?

A. Yes.

Q. Do you ever deliver the fetus such that a disarticulated part of the fetal trunk past the navel is outside the body of the mother?

A. Yes.

Q. And does that ever happen when the fetus is still living?

A. Yes.

Q. Dr. Paul, continuing to read this definition, it says that the fetus is—just to summarize it—is brought outside the body of the mother to the point we have just discussed:

> "for the purpose of performing an overt act that the person knows will kill the partially-delivered living fetus."

Do you see that language?

A. Yes.

Q. Let me ask you first, do you understand the term "overt act"?

A. Not really.

Q. I will just leave that. In those circumstances that you've [79] just described to me in doing a D&E where the fetus has been brought out in a way that could be described as being to a point where a part of the fetal trunk past the navel is outside the body of the mother, what do you do to complete the abortion?

A. I either disarticulate at the neck, or I put my forceps in and collapse the skull and complete the delivery.

Q. And in your opinion, would those steps be lethal acts that the fetus couldn't survive if it were alive before you did them?

A. I have no doubt that collapsing a skull or disarticulating at the neck would cause fetal demise.

Q. And then after taking those steps, either collapsing the calvarium or using disarticulation, do you then complete the procedure?

A. Yes.

Q. In the abortions that you have done where this has occurred where you brought the fetus out intact up to the point where the head lodges at the cervix, did you deliver the fetus to that point for the purpose of compressing the calvarium?

A. Of course not. I did it to empty the uterus.

Q. Dr. Paul, now that we have gone through the act in this way, are you still concerned about the impact of this law on your practice?

A. Oh, absolutely.

[80]

Q. Do you find any comfort in the "for the purpose of" language in this statute, given that you've told us that you don't bring the fetus out to that particular point for the purpose of collapsing the calvarium or disarticulating at the neck?

A. I find no comfort in that. I mean, I know what my purpose is. That my purpose in bringing the fetus out past the navel, the fetal trunk out past the navel is to empty the uterus in the safest way possible.

Yet, this language implies that I have this other purpose, which is to kill the fetus. So, to me, it's like—kind of like there is an elephant in the room besides me and my patient. It is not just me being allowed to do an abortion in the way that I think in my medical judgment is safest for a woman, but there is somebody judging what my purpose is in bringing the fetus out a certain way.

And I don't feel like I can practice medicine well being second-guessed by a third party about what my purpose is in completing and in doing a certain act

during an abortion when that person also has the power to put me in prison.

Q. Thank you.

MS. GARTNER: Your Honor, may I put up a second chart?

THE COURT: Yes.

BY MS. GARTNER: * * *.

* * * * *

[84]

A. Yes.

Q. And does this table contain a summary of the CDC data on abortion-related mortality broken down by what procedure was performed?

A. Yes, it does.

Q. And what do these CDC data tell us about the relative mortality of D&E and induction abortions prior to 16 weeks gestation?

A. Again, these are case fatality rates or death rates expressed as the number of abortion deaths per 100,000 legal-induced abortions.

And here, evacuation they separate out D&E. They call it "evacuation" here. And then, you have the instillation methods, are which are the induction methods that were used again at the time of the JPSA study of the—at the time that this was collected.

And what you see here is that prior to 16 weeks, that evacuation has a lower risk of death than instillation. And at 16 weeks and up, the rates are in the same ballpark.

Q. And what do these CDC data tell us about the relative mortality of either D&E or induction compared to hysterotomy or hysterectomy?

A. There's hysterectomy, hysterotomy. And as you can see, the death rates associated with hysterotomy and hysterectomy are much higher. And I would say prohibitively high. There 16 to [85] 20 weeks it is over a hundred deaths per 100,000 procedures. And here, at over—at 21 weeks and over, it is 274 deaths.

So, they are just incredibly much higher than the death rates associated with the other methods of abortion.

Q. And just to make the record clear, Dr. Paul, in the 16 to 20 week time frame, what is the approximate case fatality rate for D&E and induction abortion?

A. For D&E it is approximately 6.5 per 100,000 procedures; for instillation 7.9, for 100,000 procedures.

Q. What about over 20 weeks gestation?

A. For D&E, 11.9; and for instillation, 10.3.

Q. Now, Dr. Paul, you had testified earlier that the JPSA studies involved older methods of doing D&E and induction; is that correct?

A. That's right.

Q. Are there any studies that specifically compare the relative risks of D&E and induction abortions, as those procedures are currently performed?

A. There's a couple of small studies.

Q. Can you describe those for me?

A. One is by Autry and colleagues. And what they did was a historical cohort study, basically looking back

into medical records identifying women who've had a medical abortion, which would be the induction type of abortion and women who had D&E abortion, and then determining what the complications were with [86] those procedures.

And what they found was a higher rate of complications with induction methods than with the D&E. But it had to do mostly with retained placenta, which means that there was quite a high rate of retained placenta associated with the induction abortion that required surgical removal of the placenta through a curettage technique or by manual removal.

They also had one incidence of uterine rochsho (phonetic) associated with the medical induction procedures.

Q. In your practice, Dr. Paul, in providing induction abortions, can you describe briefly what's involved when there's a retained placenta as part of an induction abortion?

A. I did a lot of induction abortions at the University of Massachusetts Medical Center, and the medication was often successful in getting the fetus out, but the placenta remained in the uterus.

Generally, you would wait and wait. And it's kind of standard that if two hours after the delivery of the fetus the placenta has not yet delivered, that you take some kind of intervention to remove the placenta.

So, you could try to remove it manually, it's pretty uncomfortable; you can reach up and try to actually get it with your hands, or you can do basically a suction and curettage removal of the placenta.

I know at the university we often put people to [87] sleep to do that. I mean, it was a big deal for women to have gone through a whole labor process thinking they weren't going to have surgery and then end up having to be put to sleep to have the placenta removed.

Q. What are the risks—you said there was a general rule of thumb to remove the placenta after two hours if it hadn't delivered on its own.

What were the risks if the placenta remained inside the uterus longer than that?

A. That's been looked at in the literature, and basically there is an increase incidence of bleeding and fever if you have it in there for longer.

Q. Other than the Autry study, are you aware of any other recent studies comparing the modern methods of D&E with modern methods of induction abortions?

A. There is a small randomized trial by Dr. Grimes.

Q. Is that the same Dr. Grimes who is the co-director of the JPSA studies?

A. Yes, it is.

Q. Can you describe that study for me, please?

A. It was a pilot randomized study—

MR. QUINLIVAN: Your Honor, I have an objection. That study was not disclosed in either of the —either the expert report or the rebuttal expert report that was submitted by Dr. Paul.

* * * * *

[91]

A. Yes. I mean, most of what we do in abortion has not been subjected to randomized trial.

Q. Dr. Paul, what is evidence-based medicine? What does that term mean?

A. Evidence-based medicine is a way of doing medicine that takes into consideration the scientific information that is available.

Q. And under the principles of evidence-based medicine, what should a physician do if there are no studies assessing the safety of a particular technique?

A. Well, basically evidence-based medicine says that if there is good evidence that one particular method should be used, then it is our responsibility to use that method.

But where that evidence is lacking or is inadequate, that we use our best clinical judgment to render the safest care possible to our patients.

Q. So, Dr. Paul, given the comparable safety, what you've testified as the comparable safety of D&E and induction beginning at about 16 weeks gestation, based on your experience providing abortions what are some of the considerations that go into a woman's decision to pick one procedure or the other if she's having a second-trimester abortion?

A. Patient preference go one procedure over the other in my experience and from my reading of the literature. Induction abortion can be pretty trying to women, and women tend to have * * *.

* * * * *

[95]

A. Yes.

Q. And can you tell us what maternal fetal medicine is?

A. It's a subspecialty that involves the care of high risk pregnancies.

Q. Are you board certified in maternal fetal medicine?

A. No, I am not.

Q. Dr. Paul, I think you testified that in 1988 you received your master's degree in epidemiology; is that correct?

A. That's right.

Q. And I know you testified to this on direct, but can you repeat again what is encompassed within the term "epidemiology"?

A. I testified that it's the study of the distribution and determinant of health-related conditions in a population. Basically the application of research methods to determine why—who gets certain conditions and why.

Q. Is intuition ever used in the field of epidemiology?

A. Not per se, no.

Q. Why is that?

A. I'm trying to think if we're clear on the definition of intuition.

As I testified earlier, epidemiology does involve tenets of evidence-based medicine. So, where the

studies lacking, physicians can use their clinical judgment to take care of patients in the best way. I am not sure if that's what * * *.

* * * * *

[105] electronic fetal monitoring actually led to higher cesarean section rates; isn't that right?

A. Universal use of electronic fetal monitoring, yes.

Q. That was not something that anyone had thought of prior to those studies being conducted; isn't that right?

A. People might have thought about it, but they didn't know it.

Q. Dr. Paul, would you agree that if a particular abortion procedure led to a higher rate of cervical incompetence, then other procedures that that would be a complication of the first procedure?

A. If that were proved, yes.

Q. And if you wanted to look at the outcome of cervical incompetence, you would have to follow women through their next pregnancy to determine whether there was any kind of difference in rates; isn't that right?

A. Yes.

Q. Just to be clear, you yourself are not aware of any data that has considered whether the intact D&E procedure might lead to higher rates of cervical incompetence as compared to other procedures, are you?

A. No.

Q. Have you yourself followed up with women who have undergone an intact D&E through their next

pregnancy to determine whether their [*sic*] might be higher rates of cervical incompetence?

* * * * *

[108]

A. That's right.

Q. You could, for example, do a historical cohort study comparing the experience with intact D&E's as compared to disarticulation D&E's, could you not?

A. In a historical cohort study, you still have to identify some source that—where it was clear that it was an intact D&E. In my experience, it is not usually so distinctly noted.

So, historically it might be hard to just go to a medical record and determine whether, in fact, the delivery was done by disarticulation or as an intact delivery.

Q. But if some physicians who did use or did perform intact D&E's did actually record that in their records, then you would be able to do a historical cohort study comparing intact D&E's with disarticulate D&E's?

A. Yes, you could.

THE COURT: Mr. Quinlivan, we are approaching the break time. Is this a good time?

MR. QUINLIVAN: It is a good time.

THE COURT: We will break for 15 minutes.

(Recess taken at 11:45 a.m.)

(Proceedings resumed at 12:00 p.m.)

BY MR. QUINLIVAN:

Q. Dr. Paul, there are other examples in the fields —in the field of obstetrics and gynecology where a procedure that was thought to be safe have proven to be—or has proven to have * * *.

* * * * *

[110]

A. There is. Either I disarticulated it at the neck, or—in which case it wouldn't be an intact delivery, or kept the fetus intact and collapsed the skull with my forceps.

Q. And just so I am clear, when you are talking about the calvarium, you're talking about the fetus' head, right?

A. That's right.

Q. All right. Can you tell me how you would disarticulate the fetus' head in completing an intact D&E procedure?

A. I would not disarticulate the head in an intact D&E procedure.

Q. Okay. I apologize. You said you would disarticulate at the neck; is that correct?

A. Not—then I said, "but that would not be an intact."

Q. That would not be an intact?

A. That's right.

Q. Understood.

A. So, I was telling you what would happen if I was presented with that situation of having delivered everything to the head, right? There are two things that you can do. One would result in an intact.

Q. And why would the head—if you had disarticulated at the neck, why would that not be an intact procedure?

A. Because the fetus is not brought out intact or relatively intact.

Q. And in collapsing the skull, how would you go about doing * * *.

* * * * *

[123] direct, and Dr. Paul specifically testified in her deposition that she was not going to be testifying about this subject.

THE COURT: Sustained.

MR. QUINLIVAN: Sustained?

THE COURT: Yes.

MR. QUINLIVAN: Nothing further.

THE COURT: All right. Thank you. Any redirect?

MS. GARTNER: I do have one question, your honor.

[Dr. Maureen Paul—Redirect]

BY MS. GARTNER:

Q. Dr. Paul, with respect to the medical chart that you just reviewed, is it your testimony that the calvarium—what was the exact language that was used in that medical chart to describe the calvarium?

A. "Calvarium trapped in fundus."

Q. And is that something that makes the—when that occurs, does that make the procedure more difficult to complete?

A. Absolutely. It is actually one of the scariest things I see happen during a D&E.

Q. In this particular situation, what did you do to deliver the head, the calvarium?

A. What you don't want to do is to be reaching high up with your forceps to try and bring down the calvarium that is detached and trapped at the fundus, because you really have a [124] perforation risk when you do that. So what I did was to give pitocin, and sent the woman to the recovery room and gave her pitocin for awhile. It contracts the uterus and brings the pregnancy elements down to my forceps in a way that I can extract it safely. And that is, in fact, what we did.

Q. And what is pitocin?

A. Pitocin is an agent that's used also in induction abortions to cause contractions to help bring the pregnancy out.

Q. And the situation where that calvarium is trapped high up in the fundus, would that ever occur—

MR. QUINLIVAN: Your Honor, I have an objection. It was my understanding that the only way that these records would be used is if they revealed an intact procedure.

When Dr. Paul testified that this record did not evince or reveal an intact procedure, I ceased my questioning about it. So I don't believe plaintiffs are entitled to ask questions about it. And I would ask that this line of questioning be—line of questioning be stricken from the record.

MS. GARTNER: Your honor, my understanding of your ruling—and I may have misunderstood it—was that the documents, the medical records could only be

introduced into evidence in the case if they specifically revealed the existence of an intact procedure. We would not have even brought this record to Dr. Paul's attention. The government [125] did.

But I think actually this procedure revealed potentially another advantage of intact extraction versus disarticulation D&E, in that an intact extraction —this complication wouldn't occur—

THE COURT: I can clarify. My ruling was a threshold ruling I would only allow into evidence those medical records that showed that an intact procedure was used. However, it certainly—since you opened the questioning on this particular document, if you wish to proceed further on it, you may do so.

I don't quite know why this one was shown at all, but since you have already opened the door, I will allow you to ask questions on this particular document.

MS. GARTNER: Thank you, your honor.

BY MS. GARTNER:

Q. Dr. Paul, in abortions, D&E abortions in which you are able to extract the fetus intact to the point where the calvarium lodges at the cervix, do you ever encounter the situation where the calvarium becomes trapped in the fundus of the uterus?

A. No.

Q. Is that an additional safety advantage in your opinion of an intact extraction during a D&E procedure?

A. Absolutely. One of the perforations I had was exactly when I had to go after a trapped calvarium. I remember it.

* * * * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695 (RCC)

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLINE WESTHOFF, MD, MSC; CASSING HAMMOND, MD, MARK HELLER, MD, TIMOTHY R.B. JOHNSON, MD, STEPHEN CHASEN, MD, GERSON WEISS, MD, ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES ALONG WITH HIS OFFICERS, AGENTS, SERVANT, EMPLOYEES, AND SUCCESSORS IN OFFICE, DEFENDANTS

Apr. 1, 2004
10:00 a.m.

TRANSCRIPT OF TRIAL PROCEEDINGS, BEFORE THE HONORABLE RICHARD CONWAY CASEY, UNITED STATES DISTRICT JUDGE

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* * * * *

[Dr. Caroline Westhoff—Direct]

[752]

Q. Does your experience in epidemiology come to bear on making those evaluations and reevaluations?

A. I think my training and experience in epidemiology definitely informs my thinking and practice about assessing complications.

THE COURT: About assessing what?

THE WITNESS: Complications.

Q. Can you explain briefly how it informs that.

A. What I want to do, whether in our clinic or whether in the service at the Allen Pavilion, is to try to enumerate all the complications that we have identified and then relate those to the total number of cases that were done so that we can describe them, for instance, in terms of percentages. Then we can also compare that to other sources of complication rates to see whether our rates fall into the same range.

Q. When you made that assessment, do your rates fall into the same range?

A. Yes. I think our complication rates are comparable to other clinics as well as published estimates.

Q. Does Columbia University offer any training in abortion procedures?

A. Yes, we do.

Q. What type of abortion procedures are taught at Columbia?

A. We teach both medical and surgical abortion in the first trimester. We also teach D&E in the second trimester. And [753] because there are other doctors currently who carry out inductions in the second trimester, I am not sure about what teaching is done with regard to that procedure.

Q. Is the intact variation of D&E procedure taught at Columbia?

A. Yes, it is.

THE COURT: How long have you been teaching that?

THE WITNESS: I have had a fellowship program in family planning for about 5 or 6 years now, so we have been teaching this throughout that time.

THE COURT: Five or six years?

THE WITNESS: Yes, sir.

THE COURT: But just in that family planning unit?

THE WITNESS: Because several years ago we had a smaller volume of cases locally, I also encouraged the young doctors who had come to train with me to go and work in some other practice settings in order to get more experience.

THE COURT: That wasn't part of Columbia Presbyterian, was it.

THE WITNESS: Right.

THE COURT: That was in other settings?

THE WITNESS: I have sent some doctors to other settings. Now that we have sufficient volume of cases for our teaching, all the teaching happens locally at Columbia Presbyterian.

* * * * *

[758]

Q. Let me try to assist you, Dr. Westhoff, and ask you to direct your attention to page 68 of Plaintiffs' Trial Exhibit 70.

A. Thank you. Now, I'm sorry, could I have the question back, please.

MR. HUT: I can do it, if that is all right with the Court. The doctor wanted the question back and I can give it as readily as the court reporter.

THE COURT: All right.

Q. The question is, does the Clinician's Guide and your chapter refer to intact D&E as a variation of D&E?

A. Yes, it does.

Q. Do you recall what additional thing or things the Clinician's Guide says about the intact variation of D&E?

MS. GOWAN: Objection, your Honor.

THE COURT: What is the objection?

MS. GOWAN: He is asking the witness, I think, to basically read into the record information that is not in evidence.

THE COURT: Sustained.

MR. HUT: That was not my intention.

THE COURT: I don't know what it was, but that is what you asked.

Q. Dr. Westhoff, please do not refer to the guide responding to this question.

* * * * *

[Apr. 2, 2004]

[785] discerned in the fetus when amniocentesis is delivered; do you discern a similar response when you perform the surgical extraction portion of a D&E in the fetus to stimuli?

A. No, we don't.

When we are doing the D&E and the mother and the fetus are receiving intravenous analgesics and anesthetic agents, the fetus does not withdraw from the touching or grasping.

So, my interpretation of that different reaction is that the anesthesia is having an effect on the fetus.

Q. Let me now return to the question with which we started this morning, and that is to ask you from the process of assessment through dilation through the surgical component to describe your method with respect to D&E.

A. Yes.

After the assessment and the discussions that we were just alluding to, we proceed first with the use of osmotic dilators to soften and dilate the cervix. And we will decide for each patient how many dilators to use, again, depending on her personal anatomy, whether she has given birth before, how far pregnant she is and so on.

We in fact also have a separate discussion as part of the informed consent process of the use of the osmotic dilators. We insert osmotic dilators in the exam room using local anesthesia so that that process is more tolerable for the patient and we may insert dilators once or twice. We may see a [786] patient on just one day prior to the operation or two days. If we see the patient for two days, on the second day we will remove the first set of dilators and replace these with a new set of dilators in order to achieve greater dilation and, as I said, that decision is made primarily on the basis of gestational age and the woman's anatomy.

After we have allowed time for the dilation to proceed, the woman is requested to appear at the hos-

pital with an empty stomach so that we can induce general anesthesia for the D&E procedure. And in some occasional cases we will also use some misoprostol for a few hours before the procedure to additionally soften the cervix.

In the operating room, after the patient is asleep, we will remove all of the dilators, assess the condition of the cervix, and we will then rupture the amniotic membranes, allow amniotic fluid to drain and then we will insert either fingers or an instrument into the uterine cavity.

Before we can insert any instrument we do attach a tenaculum to the outside of the cervix in order to pull the cervix down and stabilize the uterus, as I described, in the first trimester procedure.

But once the cervix is stabilized we will then insert finger or uterus—finger or instrument into the uterine cavity to begin to pull down fetal parts.

In general, in our cases, we have a sonography unit in [787] the room with us standing by but we decide on a case-by-case basis how much we want to use sonography during the case.

THE COURT: That's a sonogram?

THE WITNESS: Sonogram, ultrasound, yes; to take, to image the fetal portion, the fetal parts and position.

Q. Does that conclude the description, Doctor?

A. At this point we will begin the extraction of the fetus or the evacuation of the fetus, and we can do this with a combination of traction with instruments or digital traction, until we remove the entire fetus from the uterus.

When we have removed the entire fetus, if it is in parts we do enumerate the parts to feel confident that all the fetus has been removed. And then we will remove placenta and membranes using a combination of suction curettage and sharp curettage.

Q. You mention traction in your answer, Dr. Westhoff; what is traction?

A. Traction just means pulling.

Q. With respect to your earlier testimony that these procedures all proceed variably, what are some of the factors that may vary among the D&E as performed for different patients?

A. There are differences both in—well, first of all, in the maternal anatomy every woman's cervix responds differently to the osmotic dilators, so we don't know until we begin this part [788] of the procedure how long the cervix is or how open the cervix is. We—in every case the placenta is going to be in a different position and in every case the fetus will be presenting in a different position.

In the middle trimester when we do these procedures the fetus may be head-first but the majority of the time is presenting in some other position.

At nine months 95 percent or more of the time when labor begins the fetus is head first. But in the midtrimester because there is more space in the uterus, the fetus can be in a much broader variety of positions and very roughly speaking about one third will be head-first, one third will be feet-first and one third will be in some more sideways kind of position at the beginning of the procedure. That position will affect, of course, what part of the fetus we are able to grasp as begin the case.

Q. How far, Dr. Westhoff, does the cervix dilate during a D&E, as you perform it?

A. There is really extraordinary variation and so some patients may only be one to two centimeters dilated, other women may be three to four centimeters dilated at the beginning of the case.

Women who are having a D&E because of miscarriage may have a cervix that is already open to three or four centimeters without my using any laminaria to cause that dilation.

[789]

Q. Is getting too much dilation a concern for you in your D&E practice?

A. No, it is not.

Q. Why is that?

A. I have never had a cervix dilate in a way that was inappropriate for the case.

At nine months of pregnancy during labor of course the cervix dilates on its own to about 10 centimeters in diameter overall. I have never ever seen someone respond to osmotic dilators to that degree, there is substantially less dilation, but because the fetus is smaller less dilation is adequate to carry out the D&E.

Q. Can you state whether responding to osmotic dilators the cervix dilates quickly or gradually?

A. The cervix dilates gradually in response to osmotic dilators.

As I said over—we could use them for as little as six hours, for instance, in some cases late in the first trimester, but generally we use—in the second trimester we are using osmotic dilators anywhere from 24 to

48 hours before the case and so that degree of dilation of a couple centimeters occurs over many hours. That's substantially slower than dilation that occurs during labor at term or during an

induction abortion.

Q. Why doesn't maximizing the degree of dilation harm the [790] woman's cervix in the D&E as you perform them?

A. Well the cervix is, of course, capable of dilating all the way to 10 centimeters and that is—that's the natural potential of cervical dilation and that is what is experienced during childbirth. And to our knowledge cervical dilation during childbirth is not harmful to the cervix.

What we do during a D&E is less dilation than childbirth and it occurs much more slowly than childbirth.

Q. As between D&E and induction in the second trimester, which procedure, typically, has the most dilation associated with it?

A. Induction will have more dilation during the second trimester because the fetus in fact cannot be delivered in an induction until there is enough dilation in order to expel the fetal head. And in an induction, the fetal head is intact and so has larger diameters than it does with a D&E.

Q. Are you aware of the use of laminaria with certain second trimester abortions—sorry, second trimester inductions, currently?

A. Yes.

There are a number of people using induction abortion in the second trimester will do a combination kind of treatment where they may use osmotic dilators prior to starting the induction, and we know that that use of laminaria or other osmotic dilators during an induction abortion or prior to an induction abortion will shorten the time required for an * * *.

* * * * *

[792] first pass of instruments in fact we do not succeed in removing any fetal parts so we can have an unsuccessful pass. And we can introduce instruments and remove the entire fetus at the first pass of the instruments. And of course every possibility in between those two extremes, which have all in fact occurred in my very own practice.

THE COURT: Does it vary with gestational age?

THE WITNESS: Yes, it does. But the correlation with gestational age is an imperfect one because both of the extremes that I described can occur early and late in the second trimester.

THE COURT: Have you ever perforated the uterus with one of these passes?

THE WITNESS: To my knowledge I haven't personally had—

THE COURT: That's all I'm asking.

THE WITNESS: —had a perforation. I can also tell you the statistics for my service.

THE COURT: I'm just asking you, Doctor.

THE WITNESS: Okay.

THE COURT: We have more than enough statistics here. Have you ever lacerated the cervix?

THE WITNESS: Yes . I have had patients experience cervical laceration, under my care, during D&E.

THE COURT: Yes.

[793]

BY MR. HUT:

Q. Have doctors performing D&E in your service, under your supervision, had uterine perforations during the course of D&Es they have performed, Doctor?

A. Yes.

As I was saying yesterday, I'm responsible for assessing all of our complications in order to make sure that we're taking good care of our patients and see what's going on.

In the last three years on our service we have had one cervical laceration and we have had three perforations of the uterus during D&E procedures.

THE COURT: Were these done by interns or residents?

THE WITNESS: They were done by other attending physicians or—

THE COURT: I didn't ask you that, Doctor. My questions are very simple.

THE WITNESS: No.

THE COURT: They were not done by residents.

THE WITNESS: They were not done by interns or residents.

THE COURT: Either one.

THE WITNESS: I know who was involved in each of these cases and it was not interns and residents.

BY MR. HUT:

Q. These perforations and lacerations occur in D&Es that were [794] effected with dismemberment or more relative intact, Doctor?

A. Each of these cases I am referring to occurred during a dismemberment type of D&E.

We have had no lacerations or perforations on my service with the use of an intact variant of D&E.

Q. At what point during the D&E procedure, as you do it, Dr. Westhoff, would it be decided the D&E would be proceeding by an intact or relatively intact extraction?

A. As I mentioned earlier, each step in our surgical care is really determined by the step that immediately precedes it.

My preference is to minimize the passes of instruments into the uterine cavity and my corollary preference is to remove as much of the fetus in each pass as possible and the, sort of logical goal of that is if I can remove the fetus intact I will do so. But we have to see each step of the way as we proceed, if that's possible.

Sometimes I may remove a portion of the fetus first. Possibly I will remove a leg and then, after I have removed that leg on the next pass, I'm able to bring down the entire rest of the fetus.

So, each case may have a very individual kind of progression through the steps whether it's entirely intact, entirely in pieces, or some combination between those two. And that evolves as the case proceeds and depends on what is possible for me to do in the safest manner.

[795]

Q. With respect to the dilation process in a D&E as you described it earlier, does that process differ for an intact D&E or as between intact D&E and a dismemberment D&E?

A. No, it doesn't.

We approach dilation, as I said, based on the patient's anatomy, her obstetrical history and gestational age. We don't start out with a prior intent of doing something different.

For all of our cases I would like to do an intact evacuation if possible, but everybody gets the same approach to the laminaria.

THE COURT: Going back, if I could with you a moment, Doctor, to your discussion with patients who say all of them you try and do an intact procedure?

THE WITNESS: Yes, your Honor.

THE COURT: Do you tell the mother that when you do that that you get to that stage, that part of the body, that the fetus is outside her body, you insert scissors in the base of the skull and insert them into the brain of the fetus?

THE WITNESS: I have not used those particular details but I do tell patients that my goal is to make the—

THE COURT: I'm not asking about goals, Doctor. I'm trying to find out what you really tell—

THE WITNESS: Okay.

THE COURT: —the mother what you are going to do * * *.

* * * * *

[814]

A. There is, of course, a range. I don't have a practice of watching the clock during cases, but I would say that often in the neighborhood of 20 minutes. Cases can be as short as 10 minutes and as long as an hour. If there are complications that require treatment, it can be much longer than an hour.

Q. With respect to the insertion of laminaria that you described that can occur one or two days prior, where is the woman typically after the laminaria are inserted and prior to surgery?

A. After a woman has laminaria, she may return home or return to work.

Q. Do you have an opinion, Dr. Westhoff, whether inductions may be medically less preferable for some patients undergoing abortion?

A. Yes.

Q. For what types of complications might an induction abortion be medically less preferable?

A. There are several categories of patients where an induction may be more dangerous or likely to fail. First, among women for instance where the uterus is infected, they have a condition called chorioamnionitis. The cervix is often soft and easy to dilate but the uterus will not respond well to the medication, and prompt removal of the pregnancy by doing a D&E is safer in terms of the infection and quicker. So that is one example.

[815]

In looking at the maternal anatomy, in a woman who has had certain types of previous uterine surgery there is a risk with the contractions of induction that her uterus wo upture. Therefore, while there is a range of opinio about exactly which surgeries are contraindications against induction, I think that doctors would agree that many uterine surgeries are contraindication to an induction because of the risk of uterine rupture.

Those are two major examples.

Q. What is uterine rupture, Dr. Westhoff?

A. Uterine rupture simply means that the uterus rips open. The problem with that is that, of course, the woman can hemorrhage, the hemorrhage may require, will require, immediate emergency surgery, and if the uterus cannot be repaired adequately, it may be necessary to do a hysterectomy. So uterine rupture leads to the risk of permanent loss of child-bearing capacity.

Q. What are some of the sources or origins of uterine scarring that may make an induction medically less preferable?

A. The most common type of uterine scarring is that from a previous Cesarean section. There are about 1 million Cesarean sections per year in the United States. If the Cesarean section is done high, if the incision is made high in the uterus, it is called a classical C-section, and I think most doctors would agree not to do an induction in that setting.

[816]

If a woman has had multiple C-sections low in the uterus, I think that most doctors would agree an

induction is more dangerous. I think there is a wider range of opinion if a woman has had a single C-section, whether it is safe to do an induction either in a future labor or at the time, for instance, of a possible abortion.

Q. Have you previously expressed an opinion in writing on whether women or labor is appropriate for women following a single prior C-section?

A. I have some work that is relevant to that question, yes.

Q. What did you conclude in that regard?

A. Just briefly, that there has been a lot of concern that the rate of C-sections is a million per year, and one issue is whether we could allow all women after a C-section to labor and have a vaginal birth with the next pregnancy. So there has been a lot of work over 20 years now to assess the safety of that.

I helped with a study a number of years ago to assess the risks of vaginal birth after C-section, in a study that summarized the experience of about 11 or 12,000 women attempting vaginal birth after C-section. For many of those women it is safe, but many of them require an additional C-section and they have a higher complication rate.

Q. Based on your experience, has there been any evolution from a medical viewpoint concerning the appropriateness of vaginal [817] delivery following C-section?

MS. GOWAN: Objection.

THE COURT: May I have the question, please.

(Question read)

THE COURT: Sustained. Rephrase it.

Q. Based on your review of literature, conversation with colleagues, and study in the field, has there been any evolution of point of view with respect to the appropriateness of labor following vaginal delivery?

A. Yes, there has been.

Q. What is that evolution, Doctor?

A. When I was in training in obstetrics at Kings County in the late 1970's, the rule was that any woman with a previous C-section was not allowed to labor at all. There then began a trend over the next decade to permit labor and vaginal birth after C-section, although in general not to allow an induction after a C-section.

THE COURT: When you use the word "induction," do you mean induced birth?

THE WITNESS: Yes.

THE COURT: Or an induction abortion?

THE WITNESS: I was referring right then to any kind of induction, whether it is a future pregnancy at term to be induced or the possibility of an induction for an abortion. But induction at term for a birth would be far more prevalent.

[818]

Q. What is a myomectomy, Dr. Westhoff, about which there has been some testimony from prior witnesses?

A. A myomectomy is an operation to remove benign growths from the uterus that are called fibroids or myomas. There is concern that the weakened wall of the uterus after such surgery would contraindicate an induction in a future pregnancy because of the risk of uterine rupture. The magnitude of that risk will

various according to how extensive the myomectomy was.

Q. Is myomectomy a source of uterine scarring?

A. Yes, it is.

Q. Is induction relatively less preferable in your opinion for women who have uterine scarring from myomectomy?

A. I would prefer to avoid inductions in women with uterine scarring.

Q. Dr. Westhoff, what is placenta previa?

A. That is a placenta in the position where it covers all or part of the cervical opening. Certainly the risks of placenta previa are hemorrhage as the cervix dilates. If the patient has a placenta previa and needs a second trimester abortion, I would prefer to use a D&E technique and not an induction, because of the greater risk of hemorrhage during induction.

Q. Do you see, Dr. West Westhoff, in the course of your practice, patients who experience cardiac disease during pregnancy?

A. Yes, we do.

[819]

Q. In your medical opinion, what type of abortion is the most appropriate for a woman with cardiac disease?

A. I want to rely on the cardiologists who refer such patients to me. Because of the cardiac condition of the patients, these doctors will tell me, whether it is in the second trimester or in fact for childbirth at term, that prolonged labor is dangerous to their patients because of the change in the dynamics of the blood supply. So they refer patients to me for D&E.

Q. In the course of your practice, Dr. Westhoff, do you see patients refer to you with pulmonary disorders?

A. Yes, I do.

Q. Do you have an opinion concerning whether induction is medically preferable or not with respect to women with certain pulmonary disorders?

A. For all of my patients with medical conditions, I try to make a decision in their best interest in conjunction with the specialist who is taking care of their primary problem. For patients with pulmonary disorders, I prefer to do a D&E, because fundamentally the anesthesia care during the D&E can protect the rest of their body systems, including their lung; and also because some of the drugs that are used for induction, the prostaglandins, have a risk of causing bronchospasm, which would interfere with the patient's breathing and oxygenation.

Q. Can you explain further what bronchospasm is.

[820]

A. I'm sorry. Bronchospasm is asthma. The air will not pass through the tubes in the lungs.

Q. Do you see any patients, Dr. Westhoff, who are referred to you by other doctors with bleeding disorders?

A. Yes, I do see patients who have either primary bleeding disorders, patients who have abnormalities of clotting factors and abnormalities of their platelets because that is just a primary problem in their body, or because such a problem results as a side effect when they are being treated for some other condition. So I see patients with a wide range of clotting disorders in our practice.

Q. Can you state whether, in your opinion, induction is more or less medically appropriate for women with such bleeding disorders affecting clotting factors and platelets, Doctor?

A. In consultation with the medical doctors who are primarily taking care of these patients, our preference is to take care of them with D&E where, as needed, we can replace any missing clotting factors during the short time that the procedure takes, and that minimizes the risk of hemorrhage in comparison to a more prolonged induction abortion.

Q. Are there certain types of fetal anomalies, Dr. Westhoff, that in your opinion make medical induction less preferable?

MS. GOWAN: Objection, your Honor.

THE COURT: I think I heard that question, but can you read it?

[821]

(Question read)

THE COURT: What is the objection?

MS. GOWAN: A fetal anomaly is not a maternal condition, so I believe the question is vague.

THE COURT: I will allow it.

A. Yes.

Q. What is your opinion in that respect, Dr. Westhoff?

A. Any large abnormalities of fetal anatomy will interfere with the progress of labor in flux and will therefore more likely result in a failed induction. So by and large, in the presence of large abnormalities of the

fetus, for instance, hydrocephalus, I would prefer to perform a D&E. A failed induction would mean that a patient would end up needing a D&E anyway. Rather than going through induction where there is a high risk of failure, I would prefer to start with a D&E.

Q. Is there a higher risk of failure with induction in connection with a fetal anomaly such as hydrocephalus?

A. The problem with hydrocephalus, in that case the fetus has a very large head so it is unlikely to be able to fit through the cervix. This depends of course —

THE COURT: Couldn't you just crush it then?

THE WITNESS: It would be an extra procedure to crush the head. And if you are going to do an induction, you don't actually have any access to the fetal head to crush it prior to the induction. So one would end up putting the patient through * * *.

* * * * *

[824] say 10 to 25 percent, the uterine contractions fail to expel the placenta and membranes; therefore, the patient still needs to have a D&C in order to remove that portion of the pregnancy.

THE COURT: A D&C?

THE WITNESS: A D&C, yes, sir, to remove the placenta and membranes.

Q. When the induction fails in the sense that the fetus is not expelled from the uterus, what procedures are taken with respect to that condition?

A. In most cases, if there is some degree of uterine dilation, we would proceed to a D&E.

Q. Do you have an opinion, Dr. Westhoff, regarding the safety of the intact variation of D&E?

A. Yes, I do.

Q. What is your opinion, Doctor?

A. My opinion is that the intact variation is safer for the woman than the dismemberment variation of D&E.

Q. Why in your opinion is the intact variation safer than the dismemberment variation for the woman?

A. Because we minimize the number of passes of instruments into the uterus, we can reduce or possibly eliminate the risk of perforation of the uterus or laceration of the cervix that is directly due to the instrument itself. Also, because in dismemberment D&E the fetus is removed in parts, there are bony fragments, and it is possible for the bony fragments to cause [825] perforation or laceration. With the intact variation, that risk is decreased or eliminated.

Also, with the dismemberment D&E there is a risk of small portions of the fetus remaining behind in the uterus, and that can lead to hemorrhage or infection of the uterus subsequent to the procedure. When the fetus is removed intact, that risk is reduced or eliminated.

Q. Dr. Westhoff, you made reference in your answer to the use of forceps in a dismemberment D&E. I would like to show you an exhibit.

MR. HUT: Your Honor, may I approach at this time?

THE COURT: You may.

Q. Doctor, I have handed you Plaintiffs' Trial Exhibit 144.

MR. HUT: Your Honor, I have provided in advance of the trial this morning Plaintiffs' Trial Exhibit 144 for examination by government counsel.

Q. Dr. Westhoff, what is Plaintiffs' Exhibit 144?

A. This is a surgical instrument referred to as Bierer forceps and comes from my operating room.

Q. Are forceps like the Bierer forceps that are Plaintiffs' Trial Exhibit 144 used by you during dismemberment D&E's?

A. Yes, these are.

Q. Can you describe the Bierer forceps for the Court, and in particular the clasping or grasping end of the Bierer forceps, please.

[826]

A. Yes, sir. These are a stainless steel instrument. It is about 11 inches long. At one end are finger holes to hold on to it. There is a hinge at about 7 or 8 inches along the shaft. Then at the tip of the hinge is—the tips of the instrument are each about the size of my thumb, and they are open, or fenestrated. They are smooth on the outside, and on the inside they are serrated in order to permit effective grasping.

Q. Since the external part of the clasping or grasping end of the forceps is smooth, how can those, if they do, inflict uterine perforation, Dr. Westhoff?

A. There are several ways that these can cause perforation. First of all, during a D&E procedure the uterus is very soft. When we are reaching into the uterus seeking fetal parts, it is possible just to puncture the uterus directly with the tip of the forceps. Even though the tip of the forceps is smooth and rounded, it

can easily penetrate the soft uterine wall during pregnancy. Second, when we open the forceps to grasp fetal parts, it is actually possible to grasp the interior surface of the uterine wall and tear a piece of uterus from the rest of the uterus.

Q. Dr. Westhoff, in your experience, as between the intact variation of D&E and the dismemberment variation of D&E, which has the shorter operating time?

A. In our experience—in my experience, my personal [827] experience, intact D&E has a shorter operating time.

Q. Why is that the case, Doctor?

A. If I can remove the entire fetus intact, or close to intact, it is a fairly smooth sequence of events, and I do not have to repeatedly search within the uterine cavity for additional fetal parts. The search to grasp and remove each part separately may need to be repeated as many as 10 to 20 times. That sequence of events, usually culminating in the removal of the skull, is difficult and, because it is done blindly, must done with slow and careful approaches, and that takes more time.

Q. What safety advantages, if any, Dr. Westhoff, are associated with shorter procedure time?

A. For any surgical procedure, there is just a general principle that shorter anesthesia time is safer for the patient. There are fluid shifts that can happen in the patient's body during the procedure and while under general anesthesia. So it is a safety benefit to limit the time.

In particular, during any surgery during pregnancy, there is always a risk of heavy bleeding and hemorrhage, and the more prolonged the procedure is, typi-

cally the greater the blood loss. Those are two advantages.

Q. Is there any safety advantage, Doctor, to shorter exposure to anesthesia?

A. In particular for patients with medical abnormalities, they [828] will be less likely to experience complication and will recover more quickly if they have brief exposure to anesthesia.

MS. GOWAN: Your Honor, I would like to move to strike the testimony. It is beyond the scope of Dr. Westhoff's expert report in this case. I don't believe that she opined generally at all on the effects of anesthesia and the complications that might be associated with anesthesia.

THE COURT: Mark the exhibit and, Mr. Hut. If you think something contrary—do you concede that or not?

MR. HUT: I am actually now paging, your Honor, through the expert report, which consists principally of—

THE COURT: I suggest you have one of your associates do that and you submit it to me on the break. If Ms. Gowan is correct, I will strike the testimony. If you believe she opined on this in the report, then have your associates mark it page and line.

MR. HUT: In general, your Honor, I do believe, I am confident, that she opined on general safety advantages of intact D&E and specified some. I do not know from memory whether she specified shorter exposure to anesthesia. I do know that it is—

THE COURT: If it is not there, I will strike it. Very simply, it is either there or it is not.

MR. HUT: My partner Ms. Wigmore has provided me a reference at paragraph 25— * * *.

* * * * *

[830] particular variations respecting pathological examinations?

THE COURT: That isn't going to cure it, Mr. Hut. Sustained. That's like me talking to A-Rod. I still can't hit .300.

MR. HUT: Would it were that easy, right, your Honor?

THE COURT: Would it be so easy.

Q. Dr. Westhoff, can you state whether in your opinion the intact variation of D&E facilitates a grieving by the woman or parents with respect to the D&E abortion?

A. Yes. We have taken care of several patients who have availed themselves of the opportunity to hold the fetus after a termination done by the intact D&E method, because it is the back of the skull that collapsed, since this is not disfiguring, and the face, for instance, is intact. Several of my patients have wished to hold the fetus after the procedure and have expressed gratitude that they were able to do so.

THE COURT: Would any of those patients that have expressed that desire to assist them in grieving, and certainly grieving is a serious thing, in any of those instances did you tell those mothers that what they authorized you to do was to make an incision at the base of the skull of their baby and suck its brain out?

THE WITNESS: Your Honor, I definitely—

THE COURT: It is a simple question, Doctor. Did you say that in any of those cases?

* * * * *

[832] remain even though the head is collapsed and the intracranial content suctioned out. Can you explain how that occurs?

A. Yes. The fetus has a tiny face and a relatively large head. The bones of the back of the skull are very soft. When we make an incision in the base of the skull, we don't disturb any of the skin covering the entire skull, we don't disturb the scalp. So the top and back of the head itself just collapses, looks a little wrinkly and collapsed, but the facial structures are not disturbed at all by that procedure.

Q. Do you or the hospital take any other steps to help facilitate the grieving process in circumstances where parents may indicate they desire it?

A. Yes, sir. We have clergy available to meet with our patients during their pre-op visits or on the day of their surgery. We have social workers available. And we also have a variety of referrals available. We have arrangements to permit burial of the fetus, if the patients want. And we have a protocol in place where the patients, if they wish to, can identify a funeral home, and so forth.

The hospital also has small coffins present, both for still births or for fetuses after a termination, and in the case of our D&E patients we actually have little hats available so we could in fact cover the back of the head where the incision had been made. We had a patient last year who had an unfortunate abnormality of her pregnancy and aborted twins in [833] the second

trimester, and she was able to hold both of them and have clergy present and arrange for them to be buried.

Q. With respect to the subject of your testimony a moment ago, Dr. Westhoff, how long does it typically take, in your experience, to effect compression of the skull in an intact D&E?

A. It takes less than a minute.

Q. How long does it typically take in your experience, Doctor, to locate compress the skull in a dismemberment D&E?

A. It takes several minutes. It is never less than a minute.

Q. Doctor, you referred in an earlier answer to the possibility or the counseling that you sometimes do or the offering that you sometimes do of an induction in cases where an intact fetus may be desired to facilitate the grieving process. Given that possibility, why then, in your opinion, does the intact D&E variation offer advantages?

A. To some extent, the choices here are issues of patient preference. Even with my patients who, for instance, express a desire to hold the fetus, I make sure they know that I cannot offer them a certainty that I will deliver an intact fetus. They are aware of the probability it will be dismembered, but they really don't want to undergo labor and they would still rather undergo the D&E even though they know that the possibility of delivering an intact fetus is not certain. Did I answer your question?

Q. Yes, Doctor.

THE COURT: Is this an appropriate time?

MR. HUT: I have about two more questions, or two more minutes, three more minutes, on this line. Then it would be a fine time your Honor. But I'm happy to do whatever you want.

THE COURT: Go ahead, finish up this line.

Q. Dr. Westhoff, can you state whether in your opinion there are women with specific health conditions for which an intact D&E may offer safety or health advantages?

A. Yes.

Q. What are some conditions of maternal health for which an intact D&E may offer certain advantages, in your opinion, Doctor?

A. For those of my patients who arrive to be taken care of and already have serious medical conditions, and this includes heart disease, sickle cell anemia, organ transplant, and a variety of other conditions, for those patients whose physiologic status is marginal at the start of the procedure, any complication is more catastrophic in their case. They would really be not in a good position to undergo additional surgery to care for the possible complications. In those cases I believe those patients have the most to gain from an intact D&E, where I would have an opportunity to avoid complications that in their medical condition would be unusually risky for them.

* * * * *

[836]

THE COURT: Please, be seated.

Before we commence questioning, I have reviewed the expert report and the transcript and I am

going to allow the answer to stand as is, but I am going to preclude any more detailed inquiry along that line, as far as anesthesia, Mr. Hut.

I think as far as it goes I will allow it at this stage.

MR. HUT: Thank you, your Honor. I have no wish to pursue any further examination in all events, but I appreciate the ruling.

THE COURT: All right.

BY MR. HUT:

Q. Dr. Westhoff, are you aware of any studies comparing the relevant safety of the intact variation of D&E with D&E involving dismemberment?

A. Yes, sir.

Q. What study or studies are you aware of, Doctor?

A. There is a study carried out by Dr. Chasen, who is another plaintiff in this case, which I believe has been accepted for publication in the American Journal of Obstetrics and Gynecology and is currently in press.

Q. Is the American Journal of Obstetrics and Gynecology a peer-reviewed journal?

A. Yes, it is.

* * * * *

[846] violating the ban.

BY MR. HUT:

Q. Dr. Westhoff, does the term vaginally deliver, as used in the text of the ban, Section 1531(b)(1), have a commonly understood meaning in the medical community?

A. To vaginally deliver means to remove any tissue from the uterus out of the woman's body through the vagina.

We can, for instance, refer to vaginally delivering a myoma of the uterus, we would vaginally deliver it if we remove it in that manner.

So, it is the removal of anything from the uterus out through the vagina.

Q. Do you have an understanding of the phrase "living fetus," as that may be understood in the medical community?

A. Yes. And I think a living fetus would probably be most simply interpreted as one that has a heartbeat and that would be, of course, different from a viable fetus.

THE COURT: If you delivered a living fetus vaginally, are you delivering a fetus with a heartbeat from the uterus to the vagina?

THE WITNESS: Yes.

THE COURT: You understand that?

THE WITNESS: If a fetus has a heartbeat I would consider it to be living.

THE COURT: And you understand then what that phrase [847] means, correct?

THE WITNESS: I'm sorry, your Honor. I just got confused. Yes.

THE COURT: Oh, the answer is yes.

THE WITNESS: Yes.

THE COURT: Next question.

BY MR. HUT:

Q. Within the medical community is there a commonly understood meaning of the phrase "breech presentation," Dr. Westhoff?

A. Yes.

Breech presentation means that either the feet or the buttocks of the fetus are facing the cervical canal.

Q. Within the medical community, Dr. Westhoff, is there a commonly understood meaning of the phrase "completion of delivery" as used in the text that you read a moment ago?

A. Yes.

Completion of delivery would mean that all fetal parts, including placenta and membrane, have been removed from the uterus.

Q. Let me direct your attention to the phrase "any part of the fetal trunk, past the navel, is outside the body of the mother." Based on your experience as a physician and abortion provider, do you have any understanding what that phrase means?

A. Well, the fetal trunk past the navel will include abdomen, abdominal organs, rib cage, chest and back, or back.

[848]

Q. Turn to Section 1531(b)(1)(B) please, Dr. Westhoff, on page S-37.

A. That's B at the top of S-37?

Q. Yes.

A. Okay.

Q. That states, "performs the overt act other than completion of delivery that kills the partially-delivered living fetus."

Did I read that correctly, Doctor?

A. Yes.

Q. In your opinion, if part but not all of the fetus is outside the mother, is that fetus a partially delivered one?

A. Yes.

Q. Now, I would like you to focus your attention for the moment, Dr. Westhoff, on intact D&E, asking you to direct your attention as I do so, to Section 1531(b)(1)(A) of the Act.

First, directing your attention to the phrase "vaginally delivers a living fetus," can you tell us whether or not intact D&E involves a vaginal delivery?

A. Yes, it does.

Q. When you perform an intact D&E, Dr. Westhoff, is the fetus living when you commence vaginal delivery?

A. Although I don't always check for it, I believe there is usually a heartbeat and that the fetus is living.

Q. With respect to the phrase in Section 1531(b)(1)(2) "breech presentation," and I believe you may have testified to this [849] previously, what percentage—I withdraw that comment. Let me start again. I withdraw the question.

What percentage, in your experience of intact D&Es, involve a fetus in the breech presentation?

A. Well, about one third of the time the fetus will already be in the breech presentation at the start of the case and as we progress through the case the position may change. So, other fetuses may become breech presentation as the case develops.

Q. Dr. Westhoff, when you perform an intact D&E on a fetus in breech presentation, do you vaginally deliver a living fetus until the point at which any part of the fetal trunk past the navel is outside the body?

A. Yes.

Q. Can you explain how that occurs, Dr. Westhoff?

A. With traction on the feet and legs. And right now we are talking about an entirely intact extraction, is that right?

Q. That's correct.

A. So, with traction on the feet and the legs, the buttocks and abdomen will deliver out through the cervix. And that's using traction usually with my hands and, perhaps, instruments.

Q. Directing your attention, Dr. Westhoff, to the phrase, "an overt act that the person knows will kill the partially-delivered fetus," in doing an intact D&E, do you perform an overt act after part of the fetal trunk past the navel is outside the woman's body?

[850]

A. Yes.

Q. Can you give us an example, Doctor, of the kind of overt act that you perform at that point, or that you may perform?

A. Well, one example would be cutting the umbilical cord and another example would be collapsing the skull, both of which, I believe, would be lethal.

Q. And at the time you either cut the umbilical cord or collapse the skull, is the fetus living?

A. Yes.

Q. And why do you perform the acts in question, either the cutting of the cord or the collapsing of the skull?

A. Because we need to do both of those things to continue the procedure.

THE COURT: And either act would kill the fetus, the cutting of the cord or the collapsing of the skull? Or does it take the combination?

THE WITNESS: No, no. I believe either of them would be lethal. I don't have any data about how soon the heartbeat would stop after either of those acts, but I believe either of them individually would definitely be lethal.

THE COURT: Kill the fetus?

THE WITNESS: Yes.

BY MR. HUT:

Q. Are either of those acts acts that you know will kill the fetus correct, Dr. Westhoff?

[851]

A. Yes.

Q. Directing your attention again to 1531(b)(1)(A), do you see the phrase, "deliberately and intentionally," at the beginning of the section?

A. Yes.

Q. With respect to the steps comprising an intact D&E that you just described, when you perform an intact D&E, are any of the steps that you described performed deliberately and intentionally?

A. Yes.

Every step of the procedure is done deliberately and intentionally, as is true with all surgical procedures. We proceed step by step in a deliberate and intentional manner.

Q. What is your purpose in performing an intact D&E?

A. To abort the pregnancy.

Q. Doctor, do you fear prosecution under this Act for the intact D&Es that you perform?

A. Yes, I do.

Q. Now I want to ask you some questions about the applicability of the Act to dismemberment D&E.

Does vaginal delivery, Dr. Westhoff, occur in a dismemberment D&E?

A. Yes, it does.

Q. When you perform a D&E involving dismemberment, is the fetus living when you commence with the vaginal delivery?

[852]

A. Yes, it is.

Q. Based on your experience, Dr. Westhoff, in performing D&E involving dismemberment, has it ever occurred that you have vaginally delivered a living fetus until a point at which any part of the fetal trunk, past the navel, is outside the body of the mother?

A. Yes. In multiple scenarios.

Q. Could you provide an example of one of those multiple scenarios?

A. Every case proceeds individually, but in a case I have taken care of I have brought down a leg and initially dismembered a leg so that the case had begun as a dismemberment case, but on grasping the second leg was able to pull down the buttocks and trunk and so forth and continue the case with the fetus still having a heartbeat and until the trunk past the navel was out of the cervix.

Q. Can you explain how, in the example you have just given, that part of the fetus outside the woman's body—excuse me, the part of the fetus past the navel is outside the woman's body?

A. Because using traction—

THE COURT: Can I—stop right there.

Just tearing off that one leg, that act itself would kill the fetus if nothing else happened, would it not? It would bleed to death, wouldn't it?

* * * * *

[855]

Q. Do you have any other examples or scenarios of the way D&E with dismemberment might proceed given its variability that would involve vaginal delivery of a living fetus until a point at which any part of the fetal trunk, past the navel, is outside the body of the woman?

A. Yes. Certainly, I can.

An example that I have in fact experienced myself in taking care of the patient in the recent past

involved not being able to start the procedure by bringing the feet down, using forceps and in fact first delivering part of the fetal back entirely separate from the patient.

So, that is a part of the fetal trunk above the navel that was delivered outside of the woman's body as a separate piece of the fetus.

We were then able to continue bringing the fetus down and bring the legs down and ultimately completed the abortion.

I don't remember in that case all the exact subsequent steps, but we did bring out a piece of the trunk first while the fetus was still living.

So, I fear that that particular sequence of events would also violate the ban.

Q. And in the sequence that you described, did you perform an overt act after the evacuation of the portion of the fetal trunk above the navel and while that portion was outside the body of the woman?

[856]

A. Yes.

And in that case, as it evolved, we also cut the cord and collapsed the skull, both of which are lethal acts.

Q. Again, why did you perform those lethal acts in the situation you just described?

A. In order to continue emptying the uterus and in order to continue the abortion.

Q. And at the time you performed the first of the cutting of the cord or the collapsing of the skull, was the fetus still living?

A. Yes.

Q. And at the time you performed either the first of the cutting of the cord or collapsing of the skull, did you know that such act, as performed, would be lethal?

A. Yes.

Q. Did you perform the acts, in the abortion you just described, deliberately and intentionally?

A. Yes.

Q. Now, in a dismemberment D&E, do you deliver the fetus to a certain point for the purpose of performing an act that you know would kill a fetus?

A. I go step by step for the purpose of completing the entire abortion and I know that in the course of proceeding step by step I will perform a lethal act, but—

Q. Is that step-by-step process the same for an intact D&E, [857] Dr. Westhoff?

A. Yes, it is.

Q. Now, Doctor, I would like to turn your attention or have you turn your attention to the applicability of the Act to the induction.

Does vaginal delivery—

MS. GOWAN: Object to the form of the question.

THE COURT: What's your objection?

MR. HUT: I will rephrase it, your Honor.

Q. Does vaginal delivery occur, Dr. Westhoff, in an induction?

A. Yes; vaginal delivery occurs during an induction abortion.

Q. When you perform an induction abortion, is the fetus living when you commence the vaginal delivery?

A. Yes, it is.

Q. Based on your experience in performing an induction, has it ever occurred that you have vaginally delivered a living fetus until a point at which any part of the fetal trunk, past the navel, is outside the body of the mother?

A. Yes.

Q. Now, directing your attention to the phrase, "an overt act that the person knows will kill the partially-delivered living fetus," does it ever occur, in the course of an induction procedure, that a physician must perform an overt act that he or she knows will kill the fetus?

A. Yes.

[858]

In an induction in the midtrimester it is very likely that the fetus will present in the breech position to start out with, as I said earlier.

And so, as the induction proceeds, the fetus may in fact deliver feet-first. And typically the cervix will not yet be sufficiently dilated for the larger parts of the fetal body to pass readily through. It is common for there to be some tension on the cord which may be wrapped around the body.

So, a very common occurrence during an induction delivery of a breech would be to cut the cord along the way. And in the case of a midtrimester abortion, that would be a lethal act.

Q. And when you would cut the cord in the situation you just described, would there be a part of the fetal body past the navel—excuse me, part of the fetal trunk, past the navel, outside the body of the woman at the time that you performed the lethal act?

A. Yes, it would be.

Q. And at the time you performed the lethal act, would the fetus still be living?

A. Yes, it would be.

Q. And would the cutting of the cord, as you just described it, be an act that a physician knows will kill the fetus?

A. Yes.

Q. In the type of induction that you just described, [859] Dr. Westhoff, are steps taken deliberately and intentionally?

A. The overall plan of the induction is deliberate and intentional and if the fetus delivers to that position, any subsequent action by the physician is deliberate and intentional; yes.

Q. Dr. Westhoff, will you explain why it is that physicians have a role in treating spontaneous abortions?

A. Spontaneous abortion or miscarriage can occur throughout gestation, and many spontaneous abortions do not complete on their own, the patient requires physician assistance to complete the emptying of the uterus.

And there is some portion of cases where women might complete the delivery entirely without intervention, but I would say in the majority of miscarriages, of

which there are about 800,000 per year in the United States, in at least 75 percent some medical intervention is required.

In particular, in the second trimester the cervix may be open and the patient may be bleeding or may have infection, and this can only stop or be remedied through the completion of emptying the uterus. And so, a physician must take some action to help the miscarriage be completed.

Q. And is the action the physician may take in emptying the uterus something that involves vaginal delivery?

A. Yes, it does.

Q. And when a physician may treat spontaneous abortion, may * * *.

* * * * *

[888]

A. Yes.

Q. Let me read a portion of section 14(A) of the findings. "Partial-birth abortion poses serious risks to the health of a woman undergoing a procedure. Those risks include, among other things, an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation, making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term"—

THE COURT: Keep your voice up, Mr. Hut.

MR. HUT: Yes, your Honor.

THE COURT: Thank you.

Q. —"an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, 'there are very few, if any, indications for, other than delivery of a second twin, and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death."

Did I read that correctly?

A. Yes, sir.

Q. Let's assume for this question and subsequent questions [889] that the procedure being discussed in this paragraph 14(A) is intact D&E. Based on your experience, Doctor, do you agree with the statement that intact D&E "increases a woman's risk of suffering from cervical incompetence, a result of cervical dilation"?

A. I do not agree with that statement.

Q. Why not, Dr. Westhoff?

A. I don't agree with it mainly on the basis of the fact that dilation occurs very gradually for women who undergo this procedure, and that the amount of dilation they experience is far less than the dilation that occurs at the time of childbirth. I also know of no evidence to support the statement.

Q. Based on your experience, Dr. Westhoff, do you agree with the statement that there is an increased risk of uterine rupture?

A. No, I don't agree with that statement.

Q. How about with the statement that there is an increased risk of abruption?

A. I don't agree with that statement.

Q. How about the statement that there is an increased risk of amniotic fluid embolus?

A. I don't agree with that statement.

Q. Are you aware of any literature that demonstrates increased risk of any of these complications with intact D&E?

[890]

A. I have seen no literature that describes any of these increased risks.

Q. Are you aware of any increased risk of trauma to the uterus as a result of converting the child to a footling breech position, Dr. Westhoff?

A. I am not aware of any increased risk to the uterus from the version procedure during a D&E.

Q. Why not?

THE COURT: May I have that question and answer read back.

(Record read)

Q. Why do you not agree with the statement of Congress?

THE COURT: If how she is not aware, I don't know if she could explain that. Do you want to rephrase it?

MR. HUT: Surely.

Q. You state that you are unaware of any basis for thinking that there would be any risk of trauma to the uterus as a result of conversion to a footling breech. Why do you think that there is an absence of any evidence suggesting any risk?

A. I haven't in my personal practice had any patients with a complication from that source, and that includes the practice of my group and my colleagues who are part of my group. And I have not seen any reports of such adverse kind of events in the medical literature.

Q. Does version or conversion to a footling breech occur in * * *.

* * * * *

[894] intact D&E. Based on your experience, Doctor, do you agree with the statement that intact D&E in fact poses serious risks to the long-term health of women and in some circumstances their lives?

A. No, I do not agree.

Q. Why not, Dr. Westhoff?

A. There is no biological plausibility, based on my knowledge and experience, that there are long-term health risks for women; similarly, based on my knowledge and biological plausibility, that there is a risk to their lives.

Q. Dr. Westhoff, please turn to section 13 of the findings, which appears on page S3-3.

A. Yes.

Q. Let me read the second sentence of that paragraph. "The facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman,

poses serious risks to a woman's health, and lies outside the standard of medical care."

Did I read that correctly?

A. Yes.

Q. Again, I ask you to assume that what the paragraph is talking about is intact D&E. On that assumption, do you agree with the statement by Congress in this finding that intact D&E is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care?

* * * * *

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 4:03CV8695 (RCC)

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLINE WESTHOFF, M.D., MSC; CASSING HAMMOND, M.D., MARC HELLER, M.D., TIMOTHY R.B. JOHNSON, M.D. STEHEN CHASEN, M.D., GERSON WEISS, M.D., ON BEHALF OF THEMSELVES AND THE PATIENTS THEY SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, ALONG WITH HIS OFFICERS, AGENTS, SERVANT, EMPLOYEES, AND SUCCESSORS IN OFFICE, DEFENDANTS

Apr. 15, 2004

9:55 a.m.

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* * * * *

[Dr. Steven L. Clark—Direct]

[2271] of Utah.

A. Salt Lake City, Utah.

Q. In what capacity are you employed there?

A. I am a practicing maternal fetal medicine specialist at one of the Inner Mountain Health Care facilities, LDS Hospital, and professor of obstetrics and gynecology at the Utah School of Medicine.

Q. How long have you held the position as professor of obstetrics and gynecology at the Utah School of Medicine?

A. 14 years.

Q. And would you briefly describe your duties and responsibilities as professor of obstetrics and gynecology?

A. Yes.

In my role as professor I oversee the portion of the medical school teaching program that occurs at LDS Hospital, which is a private community facility.

The medical students, residents and fellows in the University of Utah School of Medicine divide their time between the University Hospital and LDS Hospital. So, I oversee that portion of their obstetrical training at LDS Hospital. That involves patient care, it involves didactic teaching, lecturing, and, of course, on-the-job teaching as I care for patients, along with the residents and students.

Q. Where did you receive your medical training?

A. University of Wisconsin in Madison.

[2272]

Q. And when did you graduate from the University of Wisconsin?

A. Undergraduate, the degree in chemistry, 1975; and I graduated from medical school also from the University of Wisconsin in 1979.

Q. And where did you do your postgraduate training?

A. University of Southern California.

Q. And what type of postgraduate training did you do?

A. Internship and residency in obstetrics and gynecology and fellowship in maternal fetal medicine.

Q. What is maternal fetal medicine?

A. Maternal fetal medicine is the subspecialty of obstetrics that deals specifically with what you might call problem pregnancies or high risk pregnancy. So, this would be women who have medical complications of their pregnancy or who develop new pregnancy complications that could jeopardize the mother's life or health, and also fetal problems that develop in the range of lethal fetal abnormalities to fetal problems that can actually be treated while the baby is in utero and is life-prolonged in that way.

So, a gamut of fetal or maternal complications or pregnancy.

Q. As a maternal fetal specialist, do you consider both the woman—the mother and the fetus, to be your patient?

A. Yes.

Q. Are you licensed to practice medicine?

[227:3]

A. Yes.

Q. And where?

A. Utah and Montana.

Q. Are you board certified?

A. Yes.

Q. And in what speciality or specialities?

A. In the speciality of obstetrics and gynecology, and in the subspecialty of maternal fetal medicine.

Q. Do you have a further speciality within the subspeciality of maternal fetal medicine?

A. No, I wouldn't say it's a subspecialty, but it's a special interest.

There are no more defined subspecialties than just maternal fetal medicine. But within the area of maternal fetal medicine, one of my principal interests and experience has been care of the critically ill mother.

Q. Is that called critical care obstetrics?

A. Critical care obstetrics, yes.

Q. Would you please tell the Judge what critical care obstetrics is?

A. Well, it's a term that I think was formally coined when we published the first edition of the textbook, Critical Care Obstetrics, back in the late 1980s.

It is a special interest within maternal fetal medicine which deals exclusively with women who have conditions * * *.

* * * * *

[2311]

Q. Doctor, have you been asked to render an expert opinion in this case concerning maternal health and D & X abortion?

A. Yes.

Q. Have you formed an expert opinion concerning maternal health and D & X abortion?

A. Yes.

Q. What is your opinion, in summary?

A. Twofold. Number one, under no circumstance is D & X abortion necessary to preserve the life or health of the mother. Corollary to that: Under no circumstance would the abolition of this procedure in any way jeopardize the life or health of any mother regardless of what medical condition she may have.

Number two, there are in fact grave concerns regarding the long-term safety of this procedure regarding the use of this procedure. To date, there are no publications even describing this procedure. There will be one coming out. And once that data is out and appropriately analyzed, the data from that procedure regarding rate of subsequent preterm birth is so incredibly disturbing that it makes—I think it confirms what is suspected might result from this procedure in terms of long-term outcomes, and therefore it would be inappropriate to be used in the general sense.

MS. PARKER: Your Honor, I object to that last piece of the answer regarding Dr. Chasen's study and I ask that it be stricken from the record. This expert did not opine on the [2312] Chasen study in his expert report. No supplemental expert report has been submitted, and we have not had an opportunity to depose this expert on this topic.

THE COURT: Is that Ms. Parker?

MS. PARKER: Yes.

THE COURT: Calm down. I can hear you.

Ms. Gowan?

MS. GOWAN: Your Honor, indeed, as I advised plaintiffs' counsel this morning, the government is not offering Dr. Clark's expert opinion as to any of the substance or the underlying methodology or in a way to critique Dr. Chasen's paper. Certainly Dr. Clark has looked at Dr. Chasen's paper. It is going to be out there in the medical literature. He will testify just in the way that he has read that and understands that there are certain facts or conclusions pressed in the paper and that he is applying those to his opinion. He is not being offered in any way to challenge that paper.

THE COURT: I will allow it.

Q. Doctor, does your opinion in this case in any way depend on the gestational age of the fetus?

A. No. You mean the two opinions I have just given you?

Q. Yes.

A. No, they do not. That would hold without respect to the gestational age of the fetus.

Q. Could you very briefly tell us why.

[2313]

A. Sure. I can't imagine any medical condition--I have tried hard to think of one, even a hypothetical one—in which this D & X procedure might be helpful to me, as someone who spent my life caring for critically ill women, in which it might be helpful to me in preserving the life or health or well-being of the mother. I can't come up with one. I can't come up with one at 6 weeks, I can't come up with one at 18 weeks, I can't come up with one at 22 weeks. I can't come up with one at any gestational age.

Q. Does your opinion apply to those circumstances where the woman is experiencing a maternal medical complication that requires termination of her pregnancy?

A. Yes.

Q. Does your opinion apply to those circumstances where the women is carrying a fetus with an anomaly that is incompatible with life?

A. Yes.

Q. Does your opinion apply generally to the issue of safety as it may relate to the procedure?

A. Yes.

Q. Are there available methods of abortion in the second trimester that may be used to safely terminate a

pregnancy of a woman who is experiencing a maternal medical complication?

A. Yes.

Q. What are those methods?

* * * * *

[Dr. Stephen L. Clark—Cross]

[2405] was safe but until I reviewed the D & E literature I didn't realize how incredibly safe it was, so.

Q. You weren't aware before this case of how incredibly safe D & E was, right?

A. Sure. You might say I knew it was really, really safe but now I know it's really, really, really safe. Absolutely.

Q. You think that a D & E, in most cases, is preferable to an induction abortion before 18 weeks, correct?

A. Barring any medical complications that would make me choose one or the other, I would say most women would choose that, yes, and hence it would be preferable.

Q. Well, putting aside what women would choose, you currently probably would not recommend a D & E before 18 weeks, is that right?

A. That's different than the question you just asked. I do not recommend medical induction before 18 weeks.

Q. Sorry, induction.

A. Right, that was the question you meant to ask. Yes.

Q. You wouldn't recommend induction before 18 weeks. Exactly.

A. Right. All things being equal, if a woman asked my opinion exactly.

Q. If a woman asked your opinion, you wouldn't recommend an induction before 18 weeks?

A. You've got it right.

Q. Is that right?

* * * * *

[2408]

Q. You would agree that D&E beyond 20 weeks would be preferable to induction where a woman has a prior classical incision, right?

A. I've told you I believe it to be true. I can't prove it but I believe it to be true, yes.

Q. That's your opinion—

A. Yes.

Q. —although you don't have any data to support that opinion?

A. It is my opinion, yes.

Q. But it's your opinion anyway?

A. It is.

THE COURT: He said that three times.

Q. Doctor, in the late second trimester you would have a bias for D&E for a woman with a prior uterine incision, although you can't prove that it would be safer, right?

A. No. I have said it four times, yes.

Q. Okay, great.

That would be because D&E reduces the risk of uterine rupture, right, in that situation?

A. I think.

Q. You think it reduces the risk of uterine rupture in that situation?

A. I think.

Q. From a time standpoint you think a D&E might be preferable [2409] to induction in a case of severe preeclampsia at 20 to 23 weeks, right?

A. It could be, barring problems with blood clotting that we talked about before.

Q. But that's an example, barring problems with blood clotting where a D&E would be preferable from a time standpoint, is that right?

A. Sure.

Q. There are cases in which a quick surgical delivery would be preferable to a medical induction, correct?

A. Correct.

Q. One example is a case where you can't control the patient's blood pressure, right?

A. That's really the situation we just talked about. That would be the preeclampsia woman.

Q. And that's a case where you might want to do a D&E, correct?

A. Yes, sure.

Q. You would agree, Doctor, that induction of labor for abortion does not always succeed in completely emptying the uterus, correct?

A. Yes.

Q. And if an induction procedure fails to empty the uterus, you have to perform an instrument procedure to empty the uterus?

* * * * *

[2419] the Act, isn't that right?

A. Yes.

Q. Section 14A talks about the risks of partial-birth abortion to women who undergo it, correct?

A. Yes.

Q. But you don't think that anyone could say that those are the risks of the procedure, do you?

A. Would you—let me go through them again here.

THE COURT: Would you like to have that read, is it?

Do you want the question again?

THE WITNESS: No, I've got the question, I just want to read these risks to see if I agree in each case with your premise here.

Q. Of course.

A. Well, there is really only one of these which there is now some data to support, and that would be the risk of subsequent preterm birth, makes it difficult

to carry a subsequent pregnancy to term. The Chasen study gives evidence at least suggesting that that may in fact be true but these other things, in fact there is no evidence that would support that there is an increased risk of rupture, abruption, amniotic fluid embolism or trauma, and so I would disagree that one could make those statements there being no evidence that they are true.

THE COURT: You are not saying they're false, you are * * *.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 4:03CV8695 (RCC)

NATIONAL ABORTION FEDERATION, ET AL., PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, DEFENDANT

Friday, Feb. 13, 2004

Deposition of Wan J. Kim, a witness herein, called for examination by counsel for Plaintiffs in the above-entitled matter, pursuant to notice, the witness being duly sworn by Karen Young, a Notary Public in and for the District of Columbia, taken at the Offices of Wilmer Cutler Pickering LLP, 2445 M Street, Northwest, Washington, D.C. at 10:06 a.m. on Friday, February 13, 2004, and the proceedings being taken down by Stenotype by Karen Young, and transcribed under her direction.

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* * * * *

[Examination by counsel for plaintiffs by Ms. Wigmore]

[24]

A. Yes.

Q. What are those other issues?

A. They fit in no easy classification because by their very nature, they are ones that don't fall within a particular section. As I sit here this very minute, I can't think of any except maybe personnel issues or issues regarding detailing employees out of the division, et cetera.

Q. In your current position as the Deputy Assistant Attorney General, do you have any responsibility for implementing or enforcing the Partial-Birth Abortion Ban Act of 2003?

A. It's hard for me to respond to the question because I think it's—let me see if this is an answer, and then obviously you'll follow up. The Civil Rights Division is charged with the enforcement of the Partial-Birth Abortion Ban Act. There has been no implementation or enforcement as of this date based upon the orders issued by the three courts.

MS. WIGMORE: What I'd like to do just so the record is clear is to have that statute marked, so I would like to have marked as Kim Exhibit 7 this next document.

Kim Exhibit No. 7 * * *.

* * * * *

[33] described?

A. Let me see if this helps. We have from time to time issued guidance from the Department of Justice

regarding a new statute, bill, law that we expect U.S. Attorneys to be enforcing and to have some parameters for their enforcement efforts. We also issue what's called blue sheets. Blue sheets are changes to the U.S. Attorney's manual that again give the Department of Justice employees throughout the country a sense as to what the policy, practice, procedures of the department are with respect to certain laws or regulations or issues.

Those are generally the formalized procedures by which we communicate, we being the Department of Justice, thoughts on what an appropriate policy would be or what appropriate guidance would be in a certain instance.

Q. Now, you mentioned I believe that there is field guidance regarding the act; is that correct?

A. Yes.

Q. Is there any other guidance issued from within the department concerning the act?

A. Issued where?

Q. Anywhere within the Department of Justice.

A. I believe the FBI issued some guidance to [34] its field offices regarding the act.

Q. Aside from that, are you aware of any other guidance regarding the act?

A. I am not.

Q. Are you aware of any blue sheets regarding the act?

A. No, I'm not. Would you mind if I get some more coffee?

MS. WIGMORE: Not at all. Let's go off the record.

(Discussion off the record)

BY MS. WIGMORE:

Q. We'll go back to discuss those guidance documents in more detail later, but first I would like to ask you whether you did anything to prepare for today's deposition.

A. I consulted with my attorneys on occasion.

Q. Did you do anything else?

A. At some point I reviewed some documents.

Q. Did you review any documents that refreshed your recollection regarding the matters at issue in this litigation?

A. No.

Q. Did you have conversations with anyone aside from your attorneys but within the Department * * *.

* * * * *

[37]

Q. Mr. Kim, this is a lengthy document. I will direct you to certain portions, but feel free to have a look and familiarize yourself with it before I begin and let me know when you're ready.

A. I'm ready.

Q. Have you seen this document before?

A. Not to my knowledge.

Q. And for the record, this is a document titled "The Government's Amended Objections and Responses To the First Set of Discovery By Plaintiff Stephen Chasen,

M.D.", and this is a document from the case in the Southern District of New York. I'll just make that clear so there's no confusion. And what I'd like to do is direct your attention to interrogatory number 3, which appears toward the bottom of page 3.

A. I see it.

Q. And I'm just going to read the interrogatory for the record and ask you if I've read it properly. It reads, "Identify all persons with knowledge of information concerning how the act will be enforced in the event that an injunction is no longer in force in one or more of the lawsuits challenging the act's constitutionality." Did I read that correctly?

[38]

A. Yes.

Q. And now I'll read the response to interrogatory 3, which appears below it. "The government objects to such interrogatory on the grounds set forth in general objections B, E and F. Subject to and without waiving the foregoing objections, the government identifies the following person who can provide testimony subject to applicable privileges and protections on behalf of defendant concerning enforcement of the act, Wan Kim, Deputy Assistant Attorney General, Civil Rights Division, U.S. Department of Justice, Washington, D.C." Did I read that correctly?

A. You did.

Q. And that response refers to you, correct?

A. It does.

Q. Do you have knowledge of information concerning how the act will be enforced in the event

that an injunction is no longer in force in one or more of the lawsuits challenging the act's constitutionality?

A. To the extent that anybody at the department does, I believe I would be that person.

Q. And what is the basis of the knowledge you have on that topic?

[39]

A. Communications I've had with other persons within the Department of Justice.

Q. With whom?

A. Specifically communications I've had with the Assistant Attorney General for the Civil Rights Division.

Q. And that is Rene—

A. Alexander Acosta.

Q. Any other communications that provide you with information on this topic?

MR. HENRY: Just—just to be clear on the record, you're asking him about information about how the act will be enforced?

MS. WIGMORE: Yes.

THE WITNESS: No.

BY MS. WIGMORE:

Q. How will the act be enforced in the event that an injunction is no longer in force in one or more of the lawsuits challenging the act's constitutionality?

MR. HENRY: I'm going to object to the question to the extent it calls for information protected by the law enforcement investigatory privilege and the

deliberative process privilege and the mental processes privilege, and direct the [40] witness not to answer.

MS. WIGMORE: So you're instructing him not to answer the question altogether?

MR. HENRY: That's correct. Consistent with my prior statement, if you have a specific question, we'll entertain that. Based on the way the question was asked, I'm going to instruct him not to answer.

BY MS. WIGMORE:

Q. Is there any Department of Justice policy or guidance or blue sheet on how the act will be enforced in the event that an injunction is no longer in force in one or more of the lawsuits challenging the act's constitutionality?

A. Are you asking me if there's a specific document that addresses the question of what we would do once the injunction—if the injunction is removed?

Q. That's correct.

A. No.

Q. And I want to change the question slightly and not reference a document, but whether there's just a policy, whether written or unwritten, as to how the Department of Justice will enforce the act in the event there's no longer an injunction.

[41]

A. No.

Q. So is it fair to say the Department of Justice does not have a position or a policy on how that will occur, should the injunction be lifted?

A. I'm not here today as a representative of the Department of Justice. I can tell you that I am not aware of any policy or procedure that has been decided with respect to how the act will be enforced if and when the injunctions are removed.

Q. And you are the person who's been identified in the interrogatories as the individual who has knowledge or information about the enforcement of the act, correct?

A. I am.

Q. Are you aware of anyone else who might know if there is a policy or position of the Department of Justice of how the act will be enforced in the absence of an injunction?

A. I am not.

Q. Has the Department of Justice made any determination regarding what type of procedure or procedures will be subject to enforcement under the act?

A. Again, I don't sit here today as a representative of the Department of Justice. I [42] myself am not aware of such a decision.

Q. And again, you are identified as the person in the Department of Justice who has knowledge about enforcement; is that correct?

A. I am.

Q. Have you had any communications with anyone within the Department of Justice about what procedures would be subject to enforcement under the act in the absence of an injunction?

MR. HENRY: I'm going to object to the question to the extent it calls for information protected by the deliberative process privilege, the law enforcement investigatory, mental processes privilege.

MS. WIGMORE: Just so it's clear, I'm not asking what the communications were at this point. I'm asking if any such communications occurred. Are you standing by your instruction?

MR. HENRY: I'll stand by the objection but I'll permit the witness to answer.

BY MS. WIGMORE:

Q. Do you need me to repeat the question?

A. Please.

Q. Okay. Have you had any communications with anyone within the Department of Justice [43] regarding what type of procedure or procedures will be subject to enforcement under the act in the absence of an injunction?

A. I'm trying to think of the communications I've had with respect to the act. The specific communication as to what procedures would be covered in the event of the injunctions being lifted, I can't recall a specific conversation as to that issue. Any communication I've had about the act in some way informs my knowledge of the act, and that may somewhat—in some way inform what I would do in the hypothetical instance that we enforce the act as opposed to—in a set of concrete facts.

So that's why I'm not sure exactly how to respond to the question in the sense that everything I know about the act may in some way inform future decisions, but just to be clear, no decisions have been made because we have not had occasion to make them

in the context of a concrete complaint, investigation or case.

Q. Are you saying that there will be no policy or guidance as to what specific procedures will be covered by the act, but rather, those decisions will be made on a case-by-case basis?

A. Again, I don't sit here as the Justice [44] Department's representative. I am not aware of any current decision to make future decisions that would bind us in that direction. That may happen, but we have not had those kinds of communications and we certainly have not made that kind of decision.

Q. Is it fair to say that there has been no decision not to come up with such guidance and instead, to defer to the case-by-case approach?

MR. HENRY: I'm going to object to the question to the extent it calls for deliberative process protected information, information subject to the attorney-client privilege, information subject to the law enforcement investigatory privilege. I direct the witness not to answer.

BY MS. WIGMORE:

Q. Let me ask this. Has a final policy determination been made by the Department of Justice not to identify specific procedures that are covered by the act?

MR. HENRY: I'm going to object to form.

I'm not sure I understand the question.

BY MS. WIGMORE:

Q. Do you understand it, Mr. Kim?

A. I don't really understand the question either at this point.

* * * * *

[65] current role in enforcing the FACE Act.

Q. To your knowledge, does the Department of Justice have any final policy regarding whether the act will be enforced against physicians who perform procedures on fetuses that are not viable?

MR. HENRY: I'm going to object based on form. It's vague.

A. Could you say that one more time? I kind of lost you in the middle.

Q. Sure. To your knowledge, does the Department of Justice have any final policy on whether the act will be enforced against procedures performed on fetuses that are not viable?

MR. HENRY: Same objection.

A. To my knowledge, I'm not aware of any final policy decision regarding how the act would be enforced. Let me add one more clarification which may be helpful, may not be. May streamline things, probably won't. We gave considerable thought in the Civil Rights Division to the act in the days leading up to its signing by the President. I think it was on November 5th.

The act from our point of view was enjoined before it ever took effect. I will tell you that since the time that the act was enjoined, [66] apart from my preparation for this deposition, I do not believe I gave an hour, an hour and a half of thought or discussion to the act in all that time apart from my preparation for deposition and assembling documents at the request of my attorneys. Policy decisions were never made

because we had no occasion to make them, and so that may clarify things, it may not.

Q. Now, you mentioned that—I don't have your exact words, but that certain efforts went into determining how the statute would be implemented in the period before the injunction was granted. Do I have that accurate?

A. In the period before the act was signed into law and then—that's pretty much contemporaneous with the period in which the injunctions were granted.

Q. What efforts were those that you were mentioning?

A. Basically discussing the fact that the decision had been made that it would be assigned to the Civil Rights Division and helping put together some of the field guidance that was issued by the Attorney General.

Q. Anything else?

[67]

A. That's pretty much it.

Q. Does the Civil Rights Division of the Department of Justice have exclusive authority to prosecute violations of the act?

A. I am aware of a decision that I understand was made by the office of the Attorney General that the act would be assigned for enforcement to the Civil Rights Division. Now, that is the first step, history tells us, in a number of steps as to how the act actually gets enforced once and if cases arise around the country, because it could be done entirely by task force, it could be done by the U.S. Attorneys' offices with consultation, it could be done by a combination of the two. Those decisions were

never reached. The staffing decision, the actual composition of the task force—those decisions were never reached because the act was enjoined before we ever had occasion to make those final decisions.

Q. So let me just ask you to assume that the injunction is lifted. Will the department then undertake additional efforts to formulate policy about implementation?

A. If the act is to be enforced, we certainly would have to make a lot more decisions to make [68] along the way. We'd have to because it's skeletal at this point and we've never made final staffing decisions, we've never made final decisions as to how cases will be investigated, who will staff that, who will actually bring the prosecutions, where they will be coordinated. Those are all questions that we've never tackled because of the fact that the act was enjoined from day one.

Q. Is one of the issues that you have not yet tackled the scope of the procedures that will be subject to enforcement?

A. Oh, you're talking about the actual procedures by the physicians that are covered by the act?

Q. Yes.

A. Absolutely.

MS. WIGMORE: I'll put before you the next exhibit. This will be Kim Exhibit 11 I believe.

(Kim Exhibit No. 11 was marked for identification.)

BY MS. WIGMORE:

Q. Have you seen this document before, Mr. Kim?

A. I have.

* * * * *

[70] Attorneys is the Executive Office for United States Attorneys. It's sort of the administrative component for all of the U.S. Attorneys' offices within the Department of Justice in Washington, D.C., but Guy as the director of that office, it's my understanding, does not have line authority over any of the U.S. Attorneys. So he's basically there to support and help them, coordinating, interacting with main Justice.

Q. And do you see that the date at the top of this memorandum, there's a stamp of November 5th, 2003?

A. I see that.

Q. Just for the record, the text of the memorandum on this first page, which is Bates numbered DOJ ENF0008, reads, "Please find attached a memorandum from Attorney General John Ashcroft providing guidance regarding implementing the Partial-Birth Abortion Ban Act of 2003, which President Bush will sign into law today. Please distribute as necessary." Did I read that correctly?

A. You did.

Q. Do you know to whom this document was actually distributed?

[71]

A. Again, that's—do I know? I see the list. I haven't called up the U.S. Attorneys or the first assistants or the criminal chiefs or the civil chiefs or the admin officers to know whether they actually received it.

Q. Is it your understanding that it was distributed within the department?

A. Absolutely. That's my understanding.

Q. The cover page here, the first page refers to an attached memorandum. What I'd like you to do is take a look at the attachments which I just want to get some clarification on. You see the next two pages, ENF9 and ENF10, and then starting on page ENF11, there's a document entitled "Field Guidance on New Criminal Authority Enacted in the Partial-Birth Abortion Ban Act of 2003." I'm just asking for your understanding. Was it your understanding that the pages beginning on ENF11 and carrying over to ENF12 were attachments to the memorandum from the Attorney General that begins on ENF9?

A. Yes.

Q. Did you have any role in the drafting of any portion of this document?

A. You're referring to ENF0009 through ENF00012?

[72]

Q. That's correct.

A. Yes, I did.

Q. What was your role?

A. I was in—it's probably fair to say that I was the principal author. Does that make sense, in the sense that I didn't put together all the words on paper but I was the last substantive author along the way. That's probably accurate to say that.

Q. Who else worked with you on this document?

A. There was a line attorney—there was an attorney in the Civil Rights Division Criminal Section who ran the first draft.

Q. Who is that?

A. I believe his name was Bill Yeomans.

Q. Was anyone else involved?

A. The reason I hesitate is that it should have come through his chief, Al Moskowitz. It is not clear to me that Al saw the draft before Bill sent it to my office.

Q. And you signed off on the final document; is that correct?

A. No, I didn't sign off on the final document.

Q. Who did, if you know?

[73]

A. The office of the Attorney General I assume.

Q. Just so it's clear, when I say document, I was referring to the Bates numbers you referred to, ENF9 through ENF12, but just to make sure I understand things correctly, when you say you were the principal author, does that mean you were the principal author of all of those pages?

A. Yes.

Q. What was the purpose of preparing this document?

A. As I understood it?

Q. Yes.

A. To—the decision was made that this law should be explained to the Assistant U.S. Attorneys and the U.S. Attorneys and the FBI agents that would be charged with this enforcement in the field.

Q. Is that a practice that DOJ always follows when a new criminal statute is passed?

A. Not always, but often. That's my understanding.

Q. What factors determine whether or not that type of guidance is issued?

A. You're asking for our deliberative determinations on when to issue these things?

* * * * *

[84] to talk to; is that correct?

A. I think we've established that.

Q. If you could turn to the field guidance that begins on page ENF11—

A. I have it.

Q. And is this the document you've referred to earlier when I asked whether there were any formal policies or guidance within the department concerning enforcement of the act?

A. It is.

Q. If I could refer you to the second paragraph of this document, this page, I'm just going to read the second sentence, which reads, "The essential elements of a violation are that," one, "The physician must knowingly perform a partial-birth abortion, thereby killing a human fetus," and two, "The violation must be in or affecting interstate or foreign commerce." Did I read that correctly?

A. You did.

Q. And does that statement accurately reflect DOJ's policy as to what will constitute elements of a violation of the act?

A. It does.

Q. What is the basis for that statement that [85] those are the essential elements of the act?

A. It is my understanding that the basis of those statements as being the essential elements of the act are based upon a reading, a plain language reading of the act itself.

Q. Anything else besides that?

A. No.

Q. If you could refer to the next paragraph, would you agree that that paragraph addresses the definition of partial-birth abortion?

A. I would.

Q. And there's some language quoted from the statute in the first sentence, correct?

A. Yes.

Q. The second sentence of the same paragraph reads, "In sum, this definition incorporates two separate and sequential acts," colon, one, "The partial delivery of a living fetus," and two, "An overt act that kills a partially delivered living fetus." Did I read that correctly?

A. You did.

Q. And does that sentence accurately reflect how DOJ will interpret the definition of partial-birth abortion for purposes of enforcing the act?

MR. HENRY: Objection, vague.

[86]

A. I think that is exactly what you said.

Q. And what is the basis for that statement? I can read it again, but the statement reflected in the second sentence of the third paragraph of this page.

A. Again, it is based upon, as far as I understand, a plain reading of the text of the act itself.

Q. The plain reading by whom?

A. By the Attorney General, by the Department of Justice. This is guidance that is issued by the Attorney General.

Q. Do you see the phrase "A partial delivery of a living fetus" in that sentence?

A. Yes, I do.

MR. HENRY: You're referring to the last sentence?

BY MS. WIGMORE:

Q. Yes. What is partial delivery?

A. What is partial delivery?

Q. Yeah, as set forth in this guidance from DOJ.

A. I believe that is a shorthand way of trying to encapsulate the definition that was contained in the previous sentence.

[87]

Q. Does DOJ have a policy as to what constitutes a living fetus for purposes of enforcing this act?

A. DOJ has no formal final decision or policy beyond what's contained in this guidance. Not that I'm aware of at least.

Q. So the term "living fetus"—DOJ has no guidance as to what that refers to or doesn't refer to?

MR. HENRY: I'm going to object. I'll permit the witness to answer with respect to any final policy, but beyond that, it would be protected by privilege.

A. I'm not aware of that final policy regarding that term beyond what's contained in this field guidance.

Q. And I refer you to the term "overt act" that appears toward the end of the same sentence of paragraph 3.

A. Yes.

Q. Does DOJ have any policy as to what constitutes an overt act?

MR. HENRY: Same objection.

A. My answer is essentially the same, and it would be for any particular term that you want to [88] talk about. I mean, we have made this field guidance public, and beyond that, we have reached no final decision as to the meaning of specific terms. We have added no gloss beyond that.

Q. Well, you used the words "plain meaning" before, and if I could borrow those words, my question is looking back at the phrase "partial delivery," does that term have a plain meaning?

MR. HENRY: Objection, vague.

A. It does in context.

Q. And what is it?

A. Its context is right after we quote almost six and a half lines of statutory text with quotation. We're trying to summarize six lines of statutory text in a bullet way so that people can get a reference point as to what these things are referring to. It's not trying to be sneaky. It's not trying to be anything but okay, we're

interpreting and summarizing in shorthand these seven lines of definition, a complex definition by some respects, certainly for an AUSA looking at it and trying to interpret it, into these two bullet points. So we're not using that out of context or separating it from the text of the statute in any way as far as I can see.

[89]

Q. Let me just give you an example using the term "overt act" that appears in the second sentence of the third paragraph. If a physician were to cut the umbilical cord of a living fetus, would that satisfy the overt act requirement?

MR. HENRY: Objection, asked and answered. Objection, vague as to form.

A. We have never made any final decision as to how the act will be enforced in the context you've described.

Q. So is the answer to my question that you don't know one way or the other?

MR. HENRY: Objection, confusing, vague.

A. I do know that we've made no final decisions on that because they've never been confronted with an enforcement challenge yet.

Q. Is the plan to address these questions on a case-by-case basis?

A. I'm not aware of even that kind of plan because that implies that we've already decided how we're going to think through and how we're going to apply it. Our timetable really is one where if we are—if the injunctions are lifted, depending on what the court is saying, which we certainly have to read, depending on what investigations or complaints [90] are triggered,

then we'll have to make, I'm sure, some initial decisions, certainly as to how the task force will be staffed, certainly as to other things, maybe some—we'd have to make decisions as to the scope of certain language. And then other decisions certainly would have to wait a case-by-case determination, but we even haven't got to that step yet because from the moment the act was signed, it was enjoined.

Q. Well, let me ask you this. Let's assume that the injunction were lifted tomorrow. At that point how would a physician know what conduct fell within the scope of the prohibition of the act?

MR. HENRY: Objection as to form and objection, calls for speculation, objection, calls for a legal conclusion. The witness has not been presented as an expert with respect to what physicians might think, that sort of thing.

BY MS. WIGMORE:

Q. Go ahead.

MR. HENRY: If you can.

A. You're asking me to speculate. I would speculate that you would probably issue guidance, the NAF would probably issue guidance. Physicians may look up—I don't know. I really don't know. [91] I mean, I assume they would read the act, but I don't know the physician you're talking about.

Q. Let me ask about the prosecutors who act under your supervision. How will they know on the day the injunction's lifted, assuming that occurs, what type of conduct to go after?

A. We don't go after conduct before we investigate the conduct, so during the course of the investigation,

certainly decisions would have to be made, but it is not as if the moment the injunctions are lifted, if they are to be lifted, we'd have to immediately know what we're going to do in every step of the way. Those are decisions that as prosecutors we wait until they're ripe really.

Q. How will the investigators know what type of conduct to investigate?

MR. HENRY: Objection, asked and answered, vague.

BY MS. WIGMORE:

Q. Go ahead.

A. Once they get a complaint, they investigate the complaint. For example, I can just give you a prototypical case. We get an investigation—I'm sorry, of a complaint that there's a cross burning. We send out an FBI agent. [92] The FBI tries to find whether there was a cross, tries to interview witnesses, tries to determine exactly what happened. These are fact-finding expeditions in the main.

So in the course of having received a complaint, I imagine in the ordinary course of things, there would be an investigation to determine what the facts were, who were involved, what happened, when did it happen, how did it happen, what's the best evidence of that, is that evidence admissible in court. Those are the things that typically happen during the course of the investigation.

Q. What happens after the facts are collected?

A. Then decisions are made as to whether prosecution will be appropriate given the law of the statute as interpreted by judicial decisions.

Q. And is it at that point after the facts are collected that DOJ determines what procedures do and do not fall within the scope of the prohibition?

MR. HENRY: Objection, assumes facts not in evidence.

A. Yeah, I mean, again, you're trying to say that all decisions—or you're not trying to say. [93] What we are not saying is that all decisions are made at one point or all decisions are reserved. At some point in the game, it may be appropriate to make forward-reaching decisions. I will tell you that I am not aware of that point ever having been reached yet. In fact, I am aware—as far as I'm aware, that point has not been reached.

Once the point is reached to make decisions that may apply prospectively, that is certainly not necessarily the point where we would make every decision as to every possible meaning, as to every possible application. Those decisions will probably await another day because they're best probably made in the context of specific cases.

So it's not as if there will be one magic point in time when we will make every decision. It will be an evolving structure, just as it is, I believe, in the application of any statute.

Q. Now, you mentioned, and correct me if I don't get this exactly right, that some decisions have been made and others have not been made with respect to the enforcement of this statute. Am I correct in—

MR. HENRY: Objection, vague.

A. I'm not so sure about that. I mean, I [94] think what—what would be crystal clear and what I would

adopt wholeheartedly is that the only official decisions that I am aware of that have been made with respect to the act are those contained in the document that's before me right now, ENF8 through ENF12.

Q. And you would agree with me that this document does not provide specific examples of procedures that would constitute a violation of the act?

A. There are no—

MR. HENRY: Objection, vague.

A. Yeah, there are no such specific examples provided.

Q. Has the Department of Justice reached any final policy decision as to whether a physician must deliver the fetus intact in order to violate the act?

MR. HENRY: Objection, vague, asked and answered.

A. I am not aware of any such policy decision, final policy decision.

Q. And in your view, does the plain language of the act make clear whether or not a physician must deliver the fetus intact in order to violate * * *.

* * * * *

[101] within the scope of my authority.

Q. So as you sit here today, you're not in a position to answer that question?

MR. HENRY: He's not in a position to answer it based on the objection and instruction I just gave.

BY MS. WIGMORE:

Q. Could you please refer to the fourth paragraph on the same page, and I would just ask you to take a

moment to read that. I won't burden the record by reading it, but let me know when you've had a chance to do so.

A. I've read it.

Q. Would you agree with me that this paragraph addresses an exception in the statute?

A. I would.

Q. Has DOJ reached a final decision or policy as to whether in cases in which a physician performs a partial-birth abortion as defined by the statute, but could have saved the patient's life had he performed a hysterectomy, whether that would be a violation of the act?

A. DOJ has reached no final decision regarding any of the circumstances beyond what you see in the field guidance itself as far as I'm [102] aware.

Q. And I'm just going to ask the same question with a slight variation. Has DOJ reached any final decision or policy as to whether it would enforce the act against a physician who performs a partial-birth abortion as defined by the act where the physician could have saved the patient's life had he performed a hysterotomy?

MR. HENRY: Objection as to form.

A. DOJ has reached no final decision beyond what's contained in the act and—I mean, as a truthful matter, I'm not an uneducated person, but I'm not even personally aware of some of the terms you're using.

Q. Okay. I want to put before you a new exhibit, which will be Kim Exhibit 12.

(Kim Exhibit No. 12 was marked for identification.)

BY MS. WIGMORE:

Q. Please take a moment to look at this memo and let me know when you're ready to proceed.

A. I see it. I'm ready.

Q. Do you recognize this document?

A. I've seen it.

* * * * *

[115]

Q. "Objection to the form" will do. Go ahead, Mr. Kim.

A. I don't know.

Q. Has DOJ reached a policy decision as to whether the act bans only late-term abortion procedures?

MR. HENRY: Same objection as before. You can answer the question with respect to final Department of Justice policies.

A. As I've testified earlier, I am not aware of a final policy decision regarding terms beyond what was declared in the field guidance issued on November 5th.

Q. If you could refer please to the second paragraph on the next page, I want to direct your attention to the second sentence of the second paragraph, but you're welcome to read more if you wish.

MR. HENRY: And for the record, I just want to point out that that paragraph and part of the section that says "Excerpts of a Department of Justice brief opposing a temporary restraining order."

BY MS. WIGMORE:

Q. And just so the record is clear, that * * *.

* * * * *

[119]

Q. Do you see the word "intact"?

A. Let me go back.

MR. HENRY: Same objection.

A. I do not see the word "intact."

Q. Do you see in that prohibitory language any explicit exception for abortions involving dismemberment?

MR. HENRY: Same objection, and it's also not clear what section you're referring to as to the prohibitory language.

BY MS. WIGMORE:

Q. Let me rephrase the question. In Section 1531 of the act that I've put before you, do you see any explicit exception for abortions involving dismemberment of the fetus?

MR. HENRY: Same objection.

A. I don't see the word "dismemberment."

Q. And one more question about that same section, Section 1531. Do you see any explicit exemption in that provision for abortions involving inducing labor?

MR. HENRY: Same objection.

A. I don't see the word "labor" in here.

Q. You can put the act aside. Has DOJ reached any final policy decision concerning whether [120] the act will be enforced against physicians who perform abortions involving suctioning of the womb?

MR. HENRY: Objection to form.

A. I don't represent Justice Department here. I'm not aware of such a final policy decision. The only final policy decisions to the extent there are policy decisions that I'm aware of are the ones contained in the field guidance.

Q. To your knowledge, has the Department of Justice reached any final policy decision concerning whether the act exempts abortions involving dismemberment of the fetus?

MR. HENRY: I'll object as to form.

A. No, for the same reasons I just previously stated.

Q. One final question. To your knowledge, has the Department of Justice reached any final policy decision concerning whether the act exempts abortions involving inducing labor?

MR. HENRY: Object as to form.

THE WITNESS: No, for the same reasons I previously stated.

MS. WIGMORE: I will at this point conclude my questioning, but I wanted to make one statement on the record, which is that we and the * * *.

* * * * *

[Examination by counsel for Planned Parenthood Federation of America, Inc. by Mr. Evans]

[122] Gestational age is a term that I'm not familiar with. I can assume that it means how far along they are?

Q. Yes.

A. Okay.

Q. For the purposes of my questioning, gestational age means how far along the pregnancy is. Has the Department of Justice made any final policy decisions about whether or not the act will apply before a fetus is viable?

MR. HENRY: Object as to form.

A. I'm not aware of any.

Q. And has the Department of Justice made any final policy decisions about how early in the pregnancy the act will apply?

MR. HENRY: Object as to form.

A. I'm not aware of any.

Q. And so as we sit here, the act could be applied as early as 18 weeks gestational age?

MR. HENRY: Objection, calls for a legal conclusion, object as to form, requires speculation.

A. It's completely speculative because I'd have to go back and read the act and in the context of trying to interpret it to that application. It—a clarifying point may be helpful; again, it may [123] not be. It's certainly not clear to me that those decisions could not be made at some point. It's just clear to me that in the Civil Rights Division, we have not engaged in that exercise because it would have been completely hypothetical at that point. We have enough to do unfortunately that we don't need to engage in work before that work is due.

Q. Have there been discussions within—in which you have been involved about the age range within pregnancy when the act would apply?

MR. HENRY: Object as to form.

A. I'm not—I can't think of one.

Q. Do you still have the act in front of you?

A. I do.

MR. HENRY: It's Number 7.

A. Here it is, yes, I have it.

Q. You're one step ahead of me. Have I got the same version you do? Would you look at page S.3.7?

A. I have it.

Q. And in the second line on that page, do you see the phrase referring to the—as part of the definition of what is prohibited, performing an overt act?

[124]

A. I see—subsection B?

Q. Subsection B is fine, yes.

A. Yes, I see that.

Q. If I told you that a fetal demise can be caused by cutting the umbilical cord, could you tell me whether the department has made any final policy decision about whether cutting the umbilical cord would constitute an overt act?

MR. HENRY: Objection as to form.

A. I can tell you that I'm not aware of a final policy decision regarding what you just mentioned.

Q. If I told you that fetal demise could be caused by using various instruments to crush or collapse a fetal skull, could you tell me whether the department has made any policy decision about whether or not that would constitute an overt act under the law?

MR. HENRY: Object as to form. I'll permit the witness to answer as to any final policies.

BY MR. EVANS:

Q. Final policy.

A. Again, I'm not aware of a final policy decision regarding the circumstance you just [125] mentioned.

Q. And if I told you that another way of causing fetal demise would be to insert a sharp instrument into the fetal skull and then suction out the contents of the skull, would you tell me whether the department has made a final policy determination about whether or not that constitutes an overt act?

MR. HENRY: I'm going to object as to form.

BY MR. EVANS:

Q. Under the law.

A. And same answer. I mean, I can tell you that I'm not aware of a final policy regarding the circumstance you just described.

Q. And if I told you that fetal demise could be caused by using an instrument to crush the trunk of a fetus in the course of an abortion, could you tell me whether the department has made a policy—a final policy determination on whether that would constitute an overt act under the law?

MR. HENRY: Object as to form.

A. I am not aware of any final policy decision regarding the circumstance you just described.

Q. And if I told you that fetal demise could [126] be caused by detaching one or more limbs of a fetus in the course of an abortion, can you tell me whether or not

the department has made a final policy determination as to whether that would constitute an overt act under the law?

MR. HENRY: Same objection.

A. I'm not aware of any final policy decision made by the department regarding the circumstance you just described.

Q. Has the department made a final policy determination about whether or not the fetus must be intact at the time that the overt act is performed for the law to apply?

MR. HENRY: Object as to form, asked and answered.

A. Again, outside of the field guidance that was issued by the Attorney General on November 5th, I'm not aware of any other final policy decision made by the department regarding its application.

MR. EVANS: I have nothing further.

MS. SMITH: I have nothing.

MS. WIGMORE: I think we're done.

(Whereupon, at 12:51 p.m., the taking of the instant deposition ceased.)

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695 (RCC)

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLINE WESTHOFF, MD, MSC; CASSING HAMMOND, MD, MARK HELLER, MD, TIMOTHY R.B. JOHNSON, MD, STEPHEN CHASEN, MD, GERSON WEISS, MD, ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE U.S., ALONG WITH HIS OFFICERS, AGENTS, SERVANT, AND EMPLOYEES, SUCCESSORS IN OFFICE, DEFENDANTS

Apr. 19, 2004
2:00 p.m.

TRANSCRIPT OF TRIAL PROCEEDINGS, BEFORE THE HONORABLE RICHARD CONWAY CASEY, UNITED STATES DISTRICT JUDGE

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BY: LORIE CHAITEN

FOR DEFENDANTS:

ELIZABETH WOLSTEIN, ESQ.
SHEILA M. GOWAN, ESQ.
SEAN LANE
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U.S. Department of Justice
86 Chambers Street, 3rd Floor
New York, New York 10007
(212) 637-2800

* * * * *

[Dr. Joel Howell—Direct]

[2675]

THE COURT: You may.

Q. Doctor, I have handed you what has been marked Plaintiffs' Exhibit 23A. Can you identify that for the Court, please.

A. It is an article entitled "Dilation and Evacuation at Greater Than or Equal to 20 weeks: Comparison of Operative Techniques."

Q. Have you read this article?

A. Yes, I have.

Q. Doctor, please turn to the tab marked "Clark Testimony" in your binder. Hopefully, you will have a document there. Do you?

A. Yes, I do.

Q. This is the testimony of Dr. Steven Clark given on April 15, 2004, in this case. Have you had an opportunity to read this testimony?

A. Yes, I have.

Q. Doctor, Dr. Clark states that "The Chasen study shows that the rate of preterm birth after intact D&E is incredibly disturbing, downright shocking, and that intact D&E may pose significant hazards to future pregnancies in the long term in terms of preterm birth."

Q. Doctor, do you have any opinions regarding this testimony?

A. Yes, I do.

THE COURT: Whoa, whoa. Is there an objection?

* * * * *

[2677] the Chasen study, do you believe that it is possible to conclude that intact D&E would pose a significant hazard to future pregnancies in the long term in terms of preterm birth?

MR. LANE: Objection, your Honor.

THE COURT: Sustained. Ms. Chaiten, I made it quite clear what the Court was prepared to entertain as far as the area of this witness's testimony. I made it quite clear what the Court was recognizing as his area of expertise. I suspect that you have no difficulty hearing. That being the case, I would hope you would restrict your questions to the area which the Court has recognized the witness.

MS. CHAITEN: May I inquire?

THE COURT: You may, ma'am. But I would like an assurance from you that you heard me loud and clear and will restrict your questions to the appropriate area.

MS. CHAITEN: Your Honor, I have heard you and I will do my best.

THE COURT: Thank you, ma'am. You may proceed.

BY MS. CHAITEN:

Q. Dr. Howell, could you please turn to page 3 of Exhibit 23A, the Chasen study. If you will look at the last sentence beginning on the bottom of column 1 and carrying over to the top of column 2. Would you read that sentence aloud for us, please.

A. "Spontaneous preterm birth occurred in 2 of 17 (11.8 [2678] percent). Pregnancies in the intact D&X group compares with 2 of 45 (4.4 percent), and the dilation and evacuation group (P equals 3.0)."

Q. Doctor, you said P equals 3.0. Did you perhaps misread that?

A. I'm sorry. My apologies to the Court. I did in fact misread that. It should be P equals .30.

Q. Thank you, Doctor. Doctor, can you tell us what does it mean when it says P equals .30?

A. A P of .30 means that if you were to perform this same comparison over and over and over and over again, that in .30 of the experiments, that is to say 30 percent of the experiments, you would expect to see the difference that you observed or a greater difference simply due to chance alone, that is, to random variation alone.

Q. Doctor, does this suggest a threefold rate of the occurrence happening again?

A. No, it does not. May I explain?

Q. Please.

A. Were I to take a coin and flip it four times right here right now, and were it to come up heads three times and tails once, that would certainly be a 3-to-1 ratio of heads to tails. It would also be a clear trend of more heads than tails in the coin flipping. Yet I don't think that we would conclude on the basis of that experiment that the coin I held in my hand was [2679] somehow malfunctioning, that it was not a coin that truly had an equal chance of being heads or tails.

Q. What would you need in order to reach the conclusion that the coin was a troubled coin?

THE COURT: Is there an objection?

MR. LANE: Objection, your Honor. I am concerned—

THE COURT: The witness hasn't been qualified to determine what is a troubled point. Ms. Chaiten, I have warned you you must limit it to the areas in which

the witness is qualified to testify. He is not an obstetrician or gynecologist.

MS. CHAITEN: Your Honor, I am referring to the coin that he used in his example, not point.

THE COURT: Read the question again then.

(Question read)

THE COURT: "Troubled coin," what does that mean?

MS. CHAITEN: Your Honor, I will move on.

Q. Doctor, how would you apply this example that you have given us to the issue of subsequent preterm labor in the Chasen study?

A. In order to understand whether or not the findings that were seen were due to chance or not, you would need to calculate the likelihood that they were simply due to chance. In this case, the authors have provided us with that calculation, and that calculation is that the P value is equal [2680] to .30.

What that means is, just like in the coin flip we would not be likely to conclude that the coin was not a true coin, similarly in this instance, given that in 30 percent of the times one would do this experiment one would see the same kind of difference or a greater difference, one would not conclude that this was a statistically significant difference.

Q. What would a statistically significant difference be?

A. The standard for statistically significant differences in medical research is either a P of less than or equal to .05 or a P of less than or equal to .01.

Q. What does that mean?

MR. LANE: I am going to object here, your Honor. I am concerned that the question is going to elicit stuff beyond the scope of what this witness has been offered for, which is set forth in the letter.

THE COURT: I am going to allow him to continue for a while. He is a trained and experienced in the field of medical history. I don't know that he can go beyond this study. As far as I know, he has been qualified as having participated in the study. He just read it. So I will allow it for a while and let counsel go a little further.

Q. What do you mean when you refer to .05, Doctor?

A. A P value of less than or equal to .05—well, let me take a step back. We start with the assumption that we have two [2681] groups and that in fact are identical. We then do an experiment and we see a difference. I have flipped the coin four times, I saw a difference. The question that we then ask is: How likely is it that this difference is simply due to random variation, that it is simply due to chance alone?

A P value of less than .05 says that were we to do this experiment over and over and over and over again, we would only see a difference as big or bigger than the one we observed in 5 percent of the cases. We would then take this as an indication of statistical significance. If we wanted to be more stringent, we could take a P value of less than or equal to .01, which would be that you would only see that difference in 1 percent of the cases.

THE COURT: If the groups aren't identical, Doctor, would it throw all this in a cocked hat?

THE WITNESS: The calculation of these statistics assumes that the groups are comparable.

THE COURT: So if they weren't, your statement wouldn't have any meaning, would it?

THE WITNESS: The P value is an attempt to decide if indeed there is a significant difference between the two groups.

THE COURT: All right. Next question.

Q. Doctor, does the Chasen study reflect any differences between the two groups that are being compared that would [2682] affect this analysis?

A. Yes, it does.

MR. LANE: Objection, your Honor.

THE COURT: What is the objection?

MR. LANE: The objection is that this witness has been offered as to the meaning of the statistical results, and this is now getting into the substance of the actual study.

THE COURT: I will allow him. He has read it. The exhibit is in evidence and he has been asked about the P factor. I would allow him to go a little further.

A. Counselor, could you repeat the question, please.

THE COURT: Read it back, Mr. Reporter.

(Question read)

A. Yes, it does.

Q. Could you explain is that, please.

A. May I quote from the exhibit?

Q. Yes, you may, if you would please direct our attention to the place where you are quoting.

A. The top on the second column on the third page, lines 195 through 198. "Since both spontaneous premature births in the intact D&X group occurred in woman at high risk for prematurity." In other words, when I look at the difference, which is not statistically significant anyway, and I wonder if we have two groups, one of whom was already at higher risk of the event in question than the other, then this attenuates [2683] whatever—it is not a significant result anyway, and this attenuates whatever meaning it might be thought to have. This might simply be the result of one group being at higher risk than the other.

Q. Doctor, you have talked previously about P equals .30 and that that reflects a 30 percent chance—and I am going to try to get this right—that if you were to do the comparison over and over and over again, there would be a difference 30 percent of the time, is that right? Maybe I didn't get it quite right. Why don't you tell us what the 30 percent means.

A. It is a test of the assumption that the two groups are equal. What it means is if we were to do the experiment over and over and over again and there really was no difference at all, that we would expect to see a difference as great or greater 30 percent of the time.

Q. If that is what is happening 30 percent of the time, what does the 70 percent indicate?

A. 70 percent of the time you would expect to see a difference that was less than the difference observed.

Q. Doctor, does the small number of patients observed in connection with subsequent pregnancies in the Chasen study, in your opinion, render the overall study meaningless?

A. No, it does not.

Q. Why is that?

A. First of all, this was one part of a much larger study that [2684] involves considerably more patients.

THE COURT: How do you know that, Doctor?

THE WITNESS: I'm sorry. I believe the papers indicate that this was a subanalysis of one group of patients that were studied. I'm sorry, your Honor. Is that not responsive to your question?

THE COURT: Go ahead. Next question.

Q. Was there a second reason? I think you said.

A. Yes. You asked if this renders the study of no value. This is exactly the sort of study that one would expect to see logically when a new surgical technique—

MR. LANE: Objection, your Honor. The objection is that this witness is going to opine beyond the scope of what he is offered for, and I believe he is going to talk about what he was originally offered for by plaintiffs in this case, that is, surgical innovation and the role of studies.

THE COURT: Sustained.

MS. CHAITEN: Your Honor, I may have no further questions right now.

THE COURT: Mr. Lane.

MR. LANE: If I could have just one moment, your Honor?

THE COURT: Surely.

CROSS-EXAMINATION

BY MR. LANE:

* * * * *

[Seal omitted]

[Pl. Exh. No. 6]
[Dep. Exh. Cain 3]

ACOG *STATEMENT OF POLICY*
As Issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920 • Washington, D.C. 20090-6920
Telephone 202 638 5577

3. breech extraction of the body excepting the head; and
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this

procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

Approved by the Executive Board
January 12, 1997

[Pl. Exh. No. 14]
[Gov't Exh. 32D]

AMWA

The Vision and Voice of Women in Medicine

March 25, 2003

The Honorable Jerrold Nadler
House of Representatives
Washington, DC 20515

Dear Congressman Nadler:

The American Medical Women's Association (AMWA) strongly opposes HR 760, the "Partial-Birth Abortion Ban Act of 2003." While the Association has high respect for each member and their right to hold whatever moral, religious and philosophical beliefs his or her conscience dictates, as an organization of 10,000 women physicians and medical students dedicated to promoting women's health and advancing women in medicine, we believe HR 760 is unconscionable.

AMWA has long been an advocate for women's access to reproductive health care. As such, we recognize this legislation as an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available to save the life and health of the woman. Furthermore, this bill violates the privilege of a patient in consultation with her physician to make the most appropriate decision regarding her specific health circumstances.

American Medical Women's Association
801 N. Fairfax Street • Suite 400 • Alexandria, VA 22314-1757 •
Telephone: (703) 838-0500 • Fax: (703) 549-3864 • www.amwa-doc.org

AMWA opposes legislation such as HR 760 as inappropriate intervention in the decision-making relationship between physician and patient. The definition of the bill is too imprecise and it includes non-medical terminology for a procedure that may ultimately undermine the legality of other techniques in obstetrics and gynecology used in both abortion and non-abortion situations. At times, the use of these techniques is essential to the lives and health of women. The potential of this ban to criminalize certain obstetrics and gynecology techniques ultimately interferes with the quality of health and lives of women. Furthermore, the current ban fails to meet the provisions set forth by the Supreme Court in *Stenberg* v. *Carhart*, a ruling that overturned a Nebraska statute banning abortion because it contained no life and health exception for the mother.

AMWA's position on this bill corresponds to the position statement of the organization on abortion and reproductive health services to women and their families. AMWA believes that the prevention of unintended pregnancies through access to contraception and education is the best option available for reducing the abortion rate in the United States. Legislative bans for procedures that use recognized obstetrics and gynecological techniques fails to protect the health and safety of women and their children, nor will it improve the lives of women and their families. If you have any questions please contact Meghan Kissell, at 703-838-0500.

Sincerely,

/s/ LYNN C. EPSTEIN, MD
LYNN EPSTEIN, MD
President

[Pl. Exh. No. 15]
[Gov't Exh. 33D]

AMWA

The Vision and Voice of Women in Medicine

July 18, 2002

The Honorable Steve Chabot
House of Representatives
Washington, D.C. 20510

The American Medical Women's Association (AMWA) strongly opposes HR 4965, the "Partial-Birth Abortion Ban Act of 2002." The Association has high respect for each member and her right to hold whatever moral, religious, and philosophical beliefs her conscience dictates, and to practice her profession and order her personal life accordingly. As an organization of 10,000 women physicians, medical students, and residents dedicated to promoting women's health and advancing women in medicine, we believe HR 4965 is unconscionable.

AMWA has long been an advocate for women's access to reproductive health care. As such, we recognize the legislation as an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available to save the life and health of the woman. Furthermore, this bill violates the privilege of a patient in consultation with her physician to make the most appropriate decision regarding her specific health circumstances.

American Medical Women's Association
801 N. Fairfax Street • Suite 400 • Alxandria, VA 22314-1767 •
Telephone: (703) 838-0500 • Fax: (703) 549-3864 • www.amwa-doc.org

AMWA opposes legislation such as HR 4965 as inappropriate intervention in the decision-making relationship between physician and patient. The definition of the bill is too imprecise and it includes non-medical terminology for a procedure that may ultimately undermine the legality of other techniques in obstetrics and gynecology used in both abortion and non-abortion situations. At times, the use of these techniques is essential to the lives and health of women. The potential of this ban to criminalize certain obstetrics and gynecology techniques ultimately interferes with the quality of health and lives of women. Furthermore, the current ban fails to meet the provisions set forth by the Supreme Court in *Stenberg* v. *Carhart*, a ruling that overturned a Nebraska statute banning abortion because it contained no life and health exception for the mother.

AMWA's position on this bill corresponds to the position statement of the organization on abortion and reproductive health services to women and their families. The recent 2000 Position Statement on Abortion reaffirmed AMWA's commitment to supoprt policies and programs that improve women's health—a component of which is the ensured availability and access of reproductive health services to women. AMWA said:

> In light of all those considerations, the American Medical Women's Association has adopted the position that the decision to continue or interrupt a pregnancy belongs to the pregnant woman, in consultation with her physician . . . The American Medical Women's Association will oppose efforts to overturn or weaken Roe v. Wade. We will oppose laws and court rulings that interfere with the doctor-patient relationship, either in requiring or proscribing specific medical advice to pregnant

women. We will oppose measures that limit access to medical care for pregnant women, particularly for poor or undeserved groups. We support the development of new, safe, more effective methods of contraception and abortion. We believe that contraceptive prescriptions and information should be available to anyone requesting them. We support integrating comprehensive training in abortion practice into medical education. We strongly support programs that will improve the public knowledge and responsibility about sexual matters so that unintended pregnancy will become less frequent.

AMWA believes that the prevention of unintended pregnancies through access to contraception and education is the best option available for reducing the abortion rate in the United States. Legislative bans for procedures that use recognized obstetrics and gynecological techniques fails to protect the health and safety of women and their children, nor will it improve the lives of women and their families.

Sincerely,

Omega Silva, MD

[Pl. Exh. No. 17]

[Seal Omitted]

AMERICAN PUBLIC HEALTH ASSOCIATION
800 I Street, NW • Washington, DC 20001-3710
(202) 777-APHA • Fax: (202) 777-2534 •
comments@apha.org • http:///www.apha.org

March 31, 2003

U.S. House of Representatives
Washington, DC 20515

Dear Representative:

On behalf of the American Public Health Association (APHA) the largest and oldest organization of public health professionals in the nation, representing more than 50,000 members from over 50 public health occupations, I write to urge your opposition to H.R. 760, the Partial-Birth Abortion Ban Act of 2003.

APHA has long-standing policy regarding the sanctity of the provider-patient relationship and has long advocated for a woman's right to choose from a full range of reproductive health options. We believe that a physician in consultation with the patient should make the decision regarding what method should be used to terminate a pregnancy.

We are opposed to H.R. 760 because we believe this and other legislative and judicial restrictions to safe, medically accepted abortion procedures severely jeopardize women's health and well-being. APHA also opposes the bill because it fails to include adequate health exception language in instances where certain procedures may be determined by a physician to be the best or most appropriate to preserve the health of the woman.

We urge members of the House of Representatives to oppose this legislation.

Thank you for your attention to our concerns regarding the negative effect this legislation would have to a woman's right to a safe, legal abortion.

Sincerely,

/s/ GEORGES C. BENJAMIN
GEORGES C. BENJAMIN, MD, FACP
Executive Director

[Pl. Exh. No. 40]
[Nov. 5, 2003]

[Seal Omitted]

U.S. Department of Justice
Executive Office for United States Attorneys

Office of the Director *Room 2616, RFK Main Justice* (202) 514-2121
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530

MEMORANDUM

TO: ALL UNITED STATES ATTORNEYS
ALL FIRST ASSISTANT UNITED STATES ATTORNEYS
ALL CRIMINAL CHIEFS
ALL CIVIL CHIEFS
ALL ADMINISTRATIVE OFFICERS

FROM: Guy A. Lewis
Director

SUBJECT: Implementation of the Partial-Birth Abortion Act of 2003

ACTION REQUIRED: Information Only.

CONTACT PERSON: Criminal Section, Civil Rights Division
(202) 514-3204

Please find attached a memorandum from Attorney General John Ashcroft providing guidance regarding implementing the Partial-Birth Abortion Ban Act of

2003, which President Bush will sign into law today. Please distribute as necessary.

[Seal Omitted]

Office of the Attorney General
Washington, D.C. 20530

November 5, 2003

MEMORANDUM FOR THE DIRECTOR, THE FEDERAL BUREAU OF INVESTIGATION THE DIRECTOR, EXECUTIVE OFFICE OF UNITED STATES ATTORNEYS
ALL UNITED STATES ATTORNEYS
ALL SPECIAL-AGENTS-IN-CHARGE

FROM: THE ATTORNEY GENERAL

SUBJECT: Implementation of the Partial-Birth Abortion Ban Act of 2003

The President today will sign into law the Partial-Birth Abortion Ban Act of 2003 (the "Act"). The Act bans partial-birth abortions–those abortions in which a living, unborn child is killed after being partially delivered either by having the child's head or lower body past the navel outside of the mother's body. The Partial-Birth Abortion Ban Act provides both criminal and civil penalties for individuals who perform such abortions. This Act represents the judgment of the President and Congress that "partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother, blurs the line between abortion and infanticide in the killing of a

partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned." P.L. 108-XX, Section 2(14)(O).

The United States Department of Justice will play a critical role in the implementation and enforcement of this Act. The Department will enforce the Act's new criminal prohibition. I hereby direct you to review the enclosed "Field Guidance on New Criminal Authority Enacted in The Partial-Birth Abortion Ban Act of 2003," and to take all appropriate steps to implement fully and expeditiously these provisions of the Act.

Consistent with the views of both the President and Congress, the Department of Justice will enforce vigorously the criminal provisions of the Act. Enforcement will be coordinated by a task force located in the Criminal Section of the Civil Rights Division. All United States Attorneys are advised to contact the task force ((202) 514-3204) at the earliest opportunity after learning of a possible violation of the Act. It will be particularly important to involve the task force in the early phases of the implementation of the statute so that the Department of Justice can ensure a prompt and coordinated response to anticipated legal challenges.

As always, it will be vital that all components of the Department of Justice, including the United States Attorneys' Offices and Federal Bureau of Investigation Field Offices, work together to effectively and vigorously enforce this new ban on partial-birth abortions.

I thank you for your cooperation in this important effort.

Field Guidance on New Criminal Authority Enacted in The Partial-Birth Abortion Ban Act of 2003

The Partial-Birth Abortion Ban Act of 2003 (the "Act") creates new ban on partial-birth abortions. The term "partial-birth abortion" is defined by the Act to mean any abortion in which the living, unborn child, before being killed, has been partially delivered to a point specifically defined in the statute. Individuals who perform such abortions are subject to criminal and civil penalties.

The substantive prohibition in the new bill is contained in 18 U.S.C. § 1531(a), which establishes criminal liability for a "physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus." The essential elements of a violation are that (1) the physician must knowingly perform a partial-birth abortion, thereby killing a human fetus; and (2) the violation must be in or affecting interstate or foreign commerce. Section 1531(a) states that violator "shall be fined under this title or imprisoned not more than 2 years, or both."

18 U.S.C. § 1531(b)(1) defines "partial-birth abortion" as "an abortion in which the person performing the abortion (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially de-

livered living fetus." In sum, this definition incorporates two separate and sequential acts: (1) the partial delivery of a living fetus and (2) an overt act that kills the partially delivered living fetus.

The Act provides a limited exception from criminal responsibility when a partial-birth abortion "is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." 18 U.S.C. § 1531(a). The exception applies only when the procedure is necessary to save the life of the mother—and only then if the threat to her life arises from a physical (and not mental, psychological or emotional) disorder, illness or injury.

The Act applies to anyone who performs a partial-birth abortion. 18 U.S.C. § 1531(b)(2) defines "physician" to mean "a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions." The subsection, however, then clarifies that the provisions of the Act also apply to "any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion."

18 U.S.C. § 1531(d)(1) permits a physician to seek a hearing before the State Medical Board to determine "whether the physician's conduct was necessary to save the life of the mother whose life was endangered by the physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." 18 U.S.C.

§ 1531(d)(2) specifies that the findings of the State Medical Board are admissible at trial and, upon a motion of the defendant, the trial shall be delayed "for not more than thirty days to permit such a hearing to take place."

18 U.S.C. § 1531(e) excludes any woman upon whom a partial-birth abortion is performed from prosecution "under this section, for a conspiracy to violate this section, or for an offense under section 2, 3 or 4 of this title based upon a violation of this section." Therefore, no criminal or civil action may be brought under the Act against any woman who has had a partial-birth abortion.

18 U.S.C. § 1531(c)(1) creates a private cause of action for specified individuals to recover appropriate relief, including compensatory and statutory damages. The Department of Justice is not authorized by the statute to seek civil relief.